Training Manual On Women's Health For Clinicians

Women Centred Health Project

Public Health Department of Municipal Corporation of Greater Mumbai

Society for Health Alternatives (SAHAJ)

Royal Tropical Institute

Other Publications

1 *'Gatha Stree Arogyachi'* -- a resource book on reproductive health for health workers (Marathi)

2 *Puja Roy*. Women Centred Health Project, Prioritising Urban Women's Health Issues in a Public Health System, Mumbai, India, *The International Council on Management of Population Programme (ICOMP), November 2001.*

3 Paving the Way for RCH - Tools for Quality and Gender Mainstreaming.

4 Mainstreaming Quality Assurance in a Public health System: A Report

5 Training Manual for Counselling in Gynaecology Clinics

6 Stepping Stones : Training Manual for Communication on Sexuality (English and Marathi)

7 Counselling Booth in a Gynaecology Out Patient Clinic : An Evaluation Report

IEC Material Produced

- *'Mahiticha Bagicha'* (Wall chart on Reproductive Tract Infections, Marathi)
- Pamphlet on RTIs (Hindi and Marathi)
- Pamphlets on MTP (Hindi and Marathi)
- Pamphlets on ANC (Hindi and Marathi)

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PREFACE

Women Centred Health Project is a collaboration between the Public Health Department of the Brihanmumbai Municipal Corporation (BMC), SAHAJ (Vadodara) and the Royal Tropical Institute (KIT, Amsterdam).

The action research project was initiated in 1996 with the goal of providing women-centred, quality health care services through BMC's existing health facilities. Capacity building of all levels of health care providers and administrators has been a key strategy for achieving the goal. This training manual is one outcome of these capacity building efforts.

One important objective of the Women Centred Health Project was to make available essential reproductive and sexual health services for women closer to their homes. This implied that the health post and dispensaries which are the primary level health care facilities of BMC, be equipped to provide these services. The doctors in these units felt that although they had studied obstetrics and gynaecology in the under graduate medical course, their current clinical practice did not include obstetrics and gynaecology. They expressed that they needed refresher training before they could undertake any gynaecological practice.

This training manual was thus designed to upgrade the knowledge and skills of the doctors already working in BMC's health posts and dispensaries and also to enhance their social and gender perspective in relation to women's health. A unique feature of this training was the way it attempted to integrate a social - gender perspective and communication skills with the clinical content. Checklists and protocols for each clinical condition developed as aids for the clinicians, show this kind of integration.

This training manual contains detailed session outlines and field training guidelines. Also included is the resource material for each topic, resource material as handouts for the participants and aids like PowerPoint or Overhead Projection Presentations for the trainers. The annexures contain a

set of relevant tools that can be used in other situations - a task analysis of what was expected of the doctors in relation to the essential primary level reproductive and sexual health services, evaluation formats and so on.

The manual has been field tested through two batches of clinicians training. The contents have also been subsequently used in the Integrated Skill Development Training (ISDT) of the Reproductive and Child Health (RCH) Programme for medical officers, that the Public Health Department undertook for the entire Mumbai city.

The training manual was first written in 1998. It was reviewed by external reviewers in 2000 and was updated in 2003. The Clinical Sub-Committee set up by the Project guided the training as well as the development of this Manual. We acknowledge the help of the members of this Subcommittee, especially Dr. Sharad Gogate and Dr. Lalita Mayadeo. We are thankful to Dr. Dinesh Agarwal (Technical Support Unit, UNFPA, New Delhi) and Dr. Shyam Ashtekar (Director, Department of Health Sciences, Yashawantrao Chavan Mukta Vidyapith & Secretary, Bharat Vaidyak Sanstha) for reviewing the contents of the manual. We also appreciate the help of Dr. Kanchan Kumtha (Gynaecologist, BMC) in updating the contents of the resource material. Dr. Maya Hazra, (Ex-Head of Ob/Gyn. Department, Vadodara Medical College) had a final look at the resource material, we appreciate her help.

Heartfelt thanks are also due to: Dr. Vijaya Badhwar, Ms. Dilmeher Bharucha, Dr. Vinodini Desai, Ms. Rachita Dhurat, Dr. Shubha Dukle, Dr. Alka Gogate, Dr. Alka Karande, Ms. Manjiri Ketkar, Dr. Saroj Kumbhat, Dr. Uma Pocha, Dr. Pratibha Vaidya. Each of these persons have contributed in a special way to this Manual. The support of Ford Foundation is also warmly acknowledged.

Feedback on the manual, both on its relevance and usefulness will be much appreciated.

Ms. Renu Khanna **Dr. Usha Ubale** **Ms. Korrie de Koning**

GLOSSARY OF ABBREVIATIONS

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife (female)
BMC	Brihanmumbai Municipal Corporation (previously Bombay Municipal Corporation)
CDO	Community Development Officer
CHV	Community Health Volunteer
CUT	Copper T
CME	Continuing Medical Education
CSSM	Child Survival and Safe Motherhood Programme
Clerk	Clerical Office Worker
D & Cs	Dilation and Curettage
DEHO	Deputy Executive Health Officer
EHO	Executive Health Officer
FGD	Focus Group discussion
FP	Family Planning
FTMO	Full Time Medical Officer
FW	Family Welfare
GEN OPD	General out Patient Clinic
G/N	This is one of the 23 Wards of BMC ("G North"), in which the Project is taking place.
H/E	This is one of the 23 Wards of BMC ("H East"), in which the Project is taking place.
HIV/AIDS	Human Immuno-deficiency Virus / Acquired Immuno-deficiency
HHs	Household
ICPD	International Conference for Population and Development
IEC	Information, Education & Communication
IPP V	India Population Project (Five)
IUD	Intra-Uterine Devices
IPC	Inter Personal Communication
IUCD	Intra Uterine Contraceptive Device
KIT	Royal Tropical Institute, Amsterdam
LSTM	Liverpool School of Tropical Medicine
MCGM	Municipal Corporation of Greater Mumbai
MCH	Maternal and Child Health
MIS	Management Information System
MMR	Maternal Mortality Ratio
MO i/c	Medical Office in charge
MOH	Medical Officer of Health at Ward (In Charge of Public Health and PPCs/HPs)
MPW	Multipurpose Worker (Males, but more recently some females)

NGOs	Non Government Organisations
OPD	Out Patients Department
PHD	Public Health Department
PHN	Public Health Nurse
PHS	Public Health System
PID	Pelvic Inflammatory Disease
PNC	Post Natal Care
POA	Programme of Action
PPC	Post-Partum Centre
QA	Quality Assurance
QOC	Quality of Care
RCH	Reproductive and Child Health
RCHP	Reproductive Child Health Programme
RH	Reproductive Health
RNTCP	Revised National Tuberculosis Control Programme
RTIs	Reproductive Tract Infections
SAHAJ	Society for Health Alternatives
STD	Sexually Transmitted Diseases
TB	Tuberculosis
UHC	Urban Health Centre
USG	Ultra Sonography
WCHP	Women Centred Health Project

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SECTION I
Introduction

INTRODUCTION

Background and Context of Mumbai

Data about women's morbidity needs to be studied in the context of the social status of women. Reporting of morbidity is a subjective process and is dictated by one's perception of the body and its functioning as well as the socio-cultural definition of 'illness'. It has been documented that morbidity among women, especially among women in the reproductive age group, is under reported. Reasons for the under reporting are:

a. women's perceptions that equate illness to the inability to perform daily chores and, b. non-sensitivity of modern health care systems towards women's experience of morbidity that result in medical professionals not recognising some of the most commonly reported problems of back aches, weakness, and dizziness as morbidity. Morbidity has also been defined as a function of affordability and at times lack of control over resources prevents women from acknowledging their own illnesses. Taboos regarding reproductive health (RH) result in non-reporting or under reporting of RH conditions in community surveys. Even so, gynaecological illnesses have been reported among the five most common causes of morbidity among women (VHAI, 2000). NFHS-2 observed that more than half (52%) of ever married women in Mumbai suffered from abnormal vaginal discharge or urinary tract infections. This proportion was found to be much higher (62%) among slums dwellers of Mumbai (NFHS-2).

A district study in Maharashtra showed that reproductive problems, aches and pains and weakness together made up 47% of all reported morbidity. Studies have also documented the chronic nature of female morbidity in the age group of 25 to 44 years (George et al '97 page 166 in VHAI, 2000).

Infections of the reproductive tract are considered as one of the major contributing causes of gynaecological morbidity. Reproductive tract infections include (1) STIs that can lead to infertility and even death, (2) endogenous infections and (3) infections arising from harmful/unsafe obstetrics and gynaecology procedures including unsafe methods of contraception, childbirth, and abortion. The social consequences of reproductive health problems (eg infertility stigma social status) and their effects on the women's quality of life and their ability to work make these conditions serious and requiring attention by the health care systems.

Women in the reproductive age group form 49.5% of the total female population of Maharashtra (NFHS-2). Forty-nine per cent of the population of Greater Mumbai resides in slums characterised by shortage of living space, water supply and sanitation facilities. On an average, a slum household has five members and mean/average number of persons per room is four. Poor sanitary facilities mean that 80% of the slum population relies on public toilets that are not adequate either in numbers or in hygiene (98 persons per toilet in crowded areas FRCH 1999). The slum areas also face an acute shortage of water with an average of 40-50 litres per capita per day, that is, one third of the government norm of 125 LCD (Liter per capita per day) .

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Genesis of the Women Centred Health Project (WCHP)

TRAINING PROGRAMME AT A GLANCE

GOAL	To enhance the perspective, knowledge and skills of the clinicians at the health post and dispensary in the management of antenatal care and menstrual disorders, leucorrhoea, sexually transmitted infections and childlessness at the primary level.
OBJECTIVES	• To improve knowledge about women's reproductive health problems. • To understand the various socio-cultural and gender factors contributing towards women's poor health status and the management of reproductive health problems. • To strengthen the clinicians' skills in management of certain reproductive health problems. • To enhance the clinicians' communication and counselling skills.
TARGET AUDIENCE	Medical Officers working in primary level health care facilities in urban areas
GROUP SIZE	25 participants
METHODS	Highly participatory including lecturettes, small group work, case studies, role plays, and videos
DURATION AND	Workshop --- 6 half days --- 25 hours. Field Training in gynaecological clinics in the Maternity Home and Teaching hospital — 5 days --- 20 hours. Feedback session — 3 hours
DESIGN	Workshop Coordinator cum Facilitator - experienced in conducting participatory workshops. • Clinical Specialist - competent to teach the selected clinical topics. • Communication and Counselling Specialist -- with experience in Public Health. • Gender and Health Specialist

TRAINING TEAM	One training room to comfortably accommodate the entire group. Small break -out rooms, one per every 6 participants, or a room large enough so that work can be completed in small groups out of ear-shot of each other. The training room should have sufficient wall space for attaching flip charts.
TRAINING FACILITIES, MATERIALS	• Black Board and chalk. • Flip chart stands and flip chart. • Different coloured markers. • Overhead Projector. • VCR and Monitor. • Cards of different sizes and colours. • Files and note paper.
EVALUATION (Evaluation Tools are in Annexure 2)	• Evaluation of the participants through pre and post-test. • Evaluation of sessions by participants : usefulness of information, appropriateness of methodology, and duration. • Participants' evaluation of field training. • Evaluation of participants during the field training by mentor in gynaecological clinic. • Final evaluation of participants. • Ongoing quality audits by mentor.

OVERVIEW OF THE SESSIONS

SR. NO.	NAME OF THE SESSION	OBJECTIVES	METHODOLOGY	TIME
1	Introduction, Objectives Pre-test	At the end of the session the participants will be able to • understand the objectives of the training programme • know each other at more than a superficial level • do a test to provide information on baseline knowledge, skills and attitudes	• Lecturette • Introduction game • Administration of the questionnaire	120 minutes
2	Understanding Women's Health Problems	At the end of the session the participants will be ableto • list the common health problems of women, especially those related to reproductive health • describe the various factors responsible for women's poor health status	• Group discussion	150 minutes
3	Gender and Health	At the end of the session the participants will be able to • differentiate between sex and gender • state how sex and gender impact on health of individuals	• Interactive lecturette • Quiz	60 minutes
4	Scope of Health Post and Dispensary	At the end of the session the participants will be able to • describe the current situation of the health post and dispensary • discuss the scope of health post and dispensary to provide	• Discussion Presentation	60 minutes

SR. NO.	NAME OF THE SESSION	OBJECTIVES	METHODOLOGY	TIME
5	Communication Skills	At the end of this session, the participants will be able to • understand the process of communication • make an effective use of the two-way communication process • understand the barriers in effective communication that need to be overcome	• Discussion • Role plays • Exercises • Presentation	120 minutes
6	Counselling Skills	At the end of the session, the participants will be able to • describe what counselling is and what it is not • state the clients' rights in a counselling situation • identify qualities and skills of a counselor • begin to practice some specific skills of counselling	• Brain storming and discussion • Exercises • Role plays	120 minutes
7	Menstrual Problems	At the end of the session participants will be able to • understand what menstruation means to women and be able to clear myths and misunderstandings associated with it • describe the various types of menstrual problems, their causes and clinical features • differentiate between the physiological and pathological variants of the menstrual problems • diagnose and manage some of the menstrual problems at the health post and dispensary • impart information and	• Lecture • Group discussion on case studies • Presentations and on Role Plays • Field training	150 minutes

SR. NO.	NAME OF THE SESSION	OBJECTIVES	METHODOLOGY	TIME
8	Ante Natal Care / Pregnancy	At the end of this session, the participants will be able to • conduct an antenatal examination • detect high risk pregnancies and refer them to the maternity home at the earliest • give information and counsel a pregnant woman	• Lecture • Group discussion on case studies • Presentations and discussions on Role Plays • Field training	150 minutes
9	Leucorrhoea , RTI, STI	At the end of this session, the participants will be able to • differentiate between the physiological and pathological leucorrhoea • describe the various causes of leucorrhoea, RTI, and STI • understand the social and gender factors affecting leucorrhoea, RTI, and STI • diagnose and treat leucorrhoea, RTI, and STI • counsel the patients and their partners	• Lecture • Group discussion on case studies • Presentations and discussion on Role Plays • Field training	210 minutes
10	Childlessness	At the end of this session, the participants will be able to • describe the causes and management of childlessness • understand social and gender aspects of childlessness • do basic evaluation of the childless couple before referring them to a higher level • counsel the childless couple	• Lecture • Group discussion on case studies • Presentations on Role Plays • Field training	150 minutes

SR. NO.	NAME OF THE SESSION	OBJECTIVES	METHODOLOGY	TIME
11	Consultation Process and Communication with Women	At the end of this session, the participants will be able to • understand the process of consultation • apply the skills of counselling and communication to this process	• Lecture • Discussion on cases	120 minutes
12	Field training	At the end of this field training the participants will acquire skills in • history taking • examination • diagnosis • management • communication skills	• Hands on training • Observation of cases based on checklists	5 days (20 hours)
13	Feedback from the trainees on the field training	• To assess the knowledge and attitudes after the field training. • To find out from the participants whether the field training was useful, and adequate in duration. • Any problems faced. • Suggestions for improvement.	• Discussion • Filling up of the format	120 minutes
14	Post test	• To assess the knowledge and attitude of the participants after the training.	• Administration of a schedule containing questions and case studies	70 minutes

GUIDELINES FOR FACILITATORS

Adults use their own personal experiences for learning. They are exposed to lot of internal and external pressures. Adults have certain predisposed ideas, which are based on their own experiences. So adult learning is influenced by previous experiences. Adults feel they are useless if their experiences are not respected. However, this kind of thinking will hamper their learning process. Adult learning will take place effectively in a conductive atmosphere with encouragement, and respect.

The participatory training methodology believes that solutions to the problems of adults should come from their own experiences and analysis. These should be related to their life experiences. Clinicians' training uses a participatory training methodology in providing training of clinical aspects. Specific training sessions will help the trainees to look at the select gynaecological conditions in a comprehensive way.

This chapter explains different participatory training methodologies used and gives tips on how to use them effectively.

SMALL GROUP WORK

It provides an important shift from the plenary and is one of the key ways to build understanding, awareness, and skills. It also allows those participants who are more reticent about asking questions in a large group a chance to voice their opinions. In this manual small group work is used for discussion of cases and preparation of Role Plays.

Groups should be limited to no more than six participants each. Such an arrangement provides sufficient variety but minimises the time taken for presentation and feedback.

Groups can be formed randomly or this can be done systematically. For example, the facilitator might decide that separate groups should be made of the senior, articulate doctors and the junior, less experienced, reticent ones. Or that each group should have representatives of doctors from different geographical areas. These are examples of systematic group formation. Some fun can be introduced in the naming of the groups, eg while dividing the group of trainee doctors we can name the groups on the basis of medicines like Asprin, Chloroquin, Amoxycillin, etc. They can even be divided on the basis of different clinical conditions eg Infertility, Pregnancy, MTPs, etc.

For small group exercises, small rooms are needed, or a training room is required that is large enough for participants to be divided into groups at different tables so that they do not distract each other. This is important.

A change in seating arrangements can be planned the evening before the second day to ensure that different personality types and levels of knowledge and experience are spread throughout the room.

Process

Questions for discussion and cases when these are being used, should be carefully prepared before the session. Ahead of time, write the Group Task on a flip chart -- one for each group if the task is long, and if they will be working in small rooms. Inform participants of the total time they have for the group work, ask them to appoint a rapporteur and a recorder / note taker to write their findings on a flip chart. Specify the maximum time that each group will be allowed for reporting back in the plenary. Facilitators should move from group to group to ensure that the participants understand the exercise and should be available for clarifying any doubts.

Give time signals at a number of points, like at halfway time, ten minutes and three minutes before the return to plenary.

Back in the plenary, ask the groups to volunteer to report back. Allow each group specified time to present its findings. When the group's presenter has completed the report, ask other members of the group if they have anything to add. Ask the other participants for clarifying questions only (discussions will be held after all groups have made their presentations). Continue this process for all the groups.

LECTURETTES

Think about the lectures you have heard. It may be that many of them really held your rapt attention throughout. But, how much do you remember from them? Were you involved or, rather, simply a passive listener aware of the length of time. This is the disadvantage of using lecture as a method for training. Captivating lecturers have a special talent that most of us do not have.

It is well known that the attention span of adults peaks and ebbs, and this method of acquiring information can be disappointingly ineffective. Lectures tend to place the facilitator in the role of an expert, to minimise the potential for participants to examine and draw on their own knowledge and experience.

However, there IS place for lectures in a training workshop:

- Lectures provide a contrast to the other methods utilised in the workshop.
- They enable the facilitator to present information in a short space of time, and if followed by exercises that re-entrench that information, they could be extremely useful.
- A well-balanced workshop will limit the number of sessions that rely on lectures for the transmittal of information / knowledge.

Therefore in this manual you will find places in which lectures are delivered, as well as short lecturettes. The latter is much more preferable as it is short, so that the information is easier to absorb and is often a highly effective way of introducing a topic.

Delivering a Lecture / Lecturette

Some useful tips in making your lecture / lecturette as interesting as possible include:

Content

- State objectives up front
- Personalise content - experiences, illustrations, laugh at self
- Integrate anecdotes, humour, examples, and metaphors
- Try to grab attention with your openers
- Repeat core messages in different ways
- Sum up main points at the end

Preparation

- Practice with tape recorder, mirror, and video-cinema
- Over-prepare
- Write salient points on flip chart and write cues in pencil

Presentation techniques

- Use visual aids such as flip charts, OHTs containing succinct information, written in clear, large type
- Avoid notes or cue cards (eg use flip charts as above)
- Vary voice, tempo
- Avoid standing in one place and 'delivering'
- Maintain eye contact with the whole group. Don't focus on one or two participants
- Speak in a clear strong voice, with a conversational tone
- End on time !

Involving participants

Perhaps the biggest key to a successful lecture is to involve the participants. For instance:

- Encourage questions
- Pose a question and have them break into pairs or buzz groups for three minutes to discuss and give responses
- Use visual aids (flip charts, OHT/Handouts)
- Provide a short reading assignment ahead of time
- Ask for participants' experiences/ anecdotes to bear out a point
- Turn a participant's question back on the group, eg, "That's a great question. Discuss it in pairs for two minutes and lets see what you come up with."
- Begin with a brainstorming session .

BRAINSTORMING

This method allows participants to give their ideas without prior thought. Innovative and useful ideas come out from this method.

Brainstorming entails the facilitator posing a question and asking the participants to call out their spontaneous answers. Nothing is censured. Everything is written up on the blackboard, even repeats. The idea is to get as many ideas out in as short a space of time as possible. Participants will get into the rhythm of it quickly and enthusiastically. When the time is up, the facilitator then asks the group to categorise the responses into topic areas. Using colour markers, each idea is given a letter in a different colour. In the end, overlaps and repeats can be eliminated, and the ideas prioritised, if so wished. Group discussions follow during which some points might be emphasised, others discarded, until the sense of the group is achieved.

Some Guidelines

- Present a limited problem or question.
- The participants give one idea at a time.
- Record ideas on the flip chart.
- When recording, do not edit or comment.
- Only general comments allowed such as "Wow! We're getting a lot of good ideas," not praising one idea, or discarding another that is not to the point. This will stall the process as people get self-conscious.
- Keep the tempo quick.
- Ask participants not to self-censor. Tell them that some of the best ideas are the spontaneous, unfiltered ones. Comments that are critical are not allowed and evaluation of the ideas comes once the ideas have stopped flowing or the time is up.

  This is a useful exercise as it is very involving, fun, and everyone is likely to contribute.

VISUAL AIDS

The Visual Aids used most commonly in this workshop are Overhead Transparencies (OHTs) and Handouts. Sections in the manual provide ready OHTs (to be copied onto transparency sheets) and Handouts.

OVERHEAD TRANSPARENCIES (OHT)

The advantage of these visual aids is that they can contain important information in a clear and neat manner. A whole lecturette can be presented with OHTs, or they can be used intermittently to stress a point and help participants retain the information, as it is being both orally and visually presented.

When a lot of material is to be presented visually, OHTs are more useful than flip charts. They are easy to carry around.

They can be handwritten or typed, and typed OHTs can be highlighted with the use of different coloured overhead projector pens.

Disadvantages include passive interaction between participants and facilitator, the need to stare at a lighted screen, the facilitator can't move around.

How to Use OHTs

- Four or five words per line; 5/6 lines per page
- Large type
- Use colours
- Use diagrams / charts
- Use stiff cards to highlight one or two lines at a time; hide what isn't being focused on at the moment
- Cardboard frames help the handling (sheets don't fly or slide away at critical moments) and you can write cues on a cardboard for the lecture

(Source : Workshop on Gender, Health and Development - Facilitator's Guide (1997), *Pan American Health Organisation.)*

ROLE PLAY

In a Role Play, people act or pretend to be someone other than themselves. The people in the Role Play are given their characters, and they act out the situation, as they want to. Role Plays can be for two or more people.

The value of Role -Play is that by acting in it or watching it we can begin to understand why people behave as they do. Actors get a feeling for how it is to be the person in the RolePlay and can tell the audience how it feels.

"Acting certain roles evoked some bitter emotions, for example, those who acted like village women noted that they felt bad because of the treatment women get at the health units."
(Source: Health Workers for Change (1995), Women's Health Project, South Africa.)

We begin to see how it feels to be someone else. It is usually a fun way of exploring situations we are familiar with but do not often think about.

It is important to emphasise to the participants that this is acting. People are not being themselves but are acting out a role. For instance, when you discuss Role -Play, if someone from the group uses the person's real name, you should say, "You mean when she/he was acting as nurse so-and-so."

How to do Role Play?

- Explain to each person individually the role he or she is to perform. Do it privately, so that only that perso knows what the role is. Ask the people participating in the Role Play to go out and think about their roles b themselves, without talking to each other.
- While the actors are out of the room preparing, ask the group to pay attention to the content of the story an to the non-verbal communication between the actors. The group should take special note of health worke client interactions like words used, attitude, body language, and eye contact.
- When the actors come back into the room, set the scene. For example, "We are at a clinic. Mrs. 'so-and-s is the clinic nurse. The patients are now coming."
- Actors should be in full view of the group. The Role -Play should take about 10 minutes.
- It is useful to go through the following questions with the group when discussing a RolePlay
  - Ask each actor how he/she felt playing the role.
  - Ask the people watching what they thought about the way the actors related to each other.
  - Ask the group if they thought what was acted could happen in real life.
  - Ask the group why they think it happens in this way.
  - You can ask if there are things that should be different and, if so, how they should be done.
  - Sometimes people disagree and the group can talk about it.
  - If you have time and the discussion is interesting, you can ask other volunteers to come up and act th same situation differently to illustrate a point in the discussion.
  - Sometimes someone in the group can be very sure it can be different. But when you get them to act the can see it is not so easy when they are acting that role.
  - Remember during the discussion to ask the question, "do you think this would be different if the healt worker was male?" or "if the patient was male?"(as appropriate)

CASE STUDIES

Case Studies are the acceptable teaching method for clinicians. All through their under graduate and pos graduate medical education, medical students are taught on live patients in wards and outpatient clinics Trainers can prepare typical case studies of conditions and patients. These can be used for either analysis an discussion or, if skills enhancement is the objective of a session, used as a basis for role plays. Case studie can be effectively used by giving specific questions, guidelines or a framework for discussion, depending on th objectives of the training session.

STORY TELLING

Story telling is a feature of many cultures. In cultures where the oral tradition (telling stories aloud rather tha writing them down) is strong, story telling is an especially familiar and powerful tool.

The best kind of story is one made up by you that is appropriate to your situation. There are many ways of creating a story

- Talking to people about their lives and using bits and pieces from each person's experiences.
- Getting a group of women to make up the story.
- Making up a story and then checking it with some local women to see if they think it is realistic.

As you make up your story, remember the following rules that will help make sure that the objectives of the workshop are met:

- The story should cover a large part of a woman's life and not only her reproductive years.
- The story needs to include information about where the woman lives, what work she does and her home circumstances.
- People listening to the story must empathise with the woman, in other words, they need to be able to feel as she would. They need to put themselves in her place.
- It is important that the story be told as you would tell a story to your friends or to children. In a culture with a strong oral tradition, the story should be told as stories are usually told in that culture. Telling the story aloud also includes people who cannot read, where handing written copies would exclude them.

Once you have told the story aloud, ask people to talk about it and facilitate the discussion. The aim of this discussion is to:

- Identify things in the story that may be difficult for the women and why.
- Find out if any of these things are likely to make a woman ill in any way and, if so, in what way.
- Think of things that can be done to deal with these problems in her life.
- Remember in the discussion to ask the question, "what would a man do in a similar situation?" (where appropriate).
- Develop a list of the things that cause problems for this woman.
- Divide the list into things that can be dealt with by the health service and those that require help from outside the health service, like roads and transport. For those that the health service can deal with, discuss which ones would be new services, or new or better ways of providing the same services (ie increasing the quality of care). Then ask if these new services can, in fact, be provided. What would be required in order for health services to provide these extra things?

(Sources: ***Health Workers for Change*** *(1995), Women's Health Project, South Africa.*

Workshop on Gender, Health and Development - Facilitator's Guide *(1997), Pan American Health Organisation.)*

SECTION II
Session Outlines

SESSION ONE: INTRODUCTION

Objectives

At the end of this session, the participants will be able to

- understand the objectives of the training programme.
- know each other at more than a superficial level.
- do a test to provide information on baseline knowledge, skills and attitudes

Methodology

- Lecturette
- Introduction game
- Administration of the questionnaire

Resources

- OHP and Transparencies (OHT 1)
- Pre-test schedule (Annexure 2.4)

Time

120 minutes

Process

Activity 1 Introduction to the objectives of the training programme (30 minutes)

Facilitator and the training team welcome the participants.

- The objective of the training programme is explained through OHT (OHT1).
- Questions are invited for clarifications.

Activity 2 Introductions (30 minutes)

Ask the participants to find a partner that they know the least about.

- For five minutes each pair has to tell each other an adjective that describes him/her, two aspects of work that they like the most, two aspects of family life that they really appreciate.
- After the five-minute session the group will meet and the partners will introduce each other.
- Facilitators makes two or three concluding observations about highlights of the process reinforcing that we know each other better now and expressing a hope that together we would build a environment for mutual learning.

Activity 3 Pre-test (60 minutes)

The facilitator distributes the pre-test schedules clarifying the objective of the pre-test as providing information to guide the resource persons and also to assess the training by comparing pre and post test scores.

- Facilitator specifies that 60 minutes are given to complete the test.

SESSION TWO: UNDERSTANDING WOMEN'S HEALTH PROBLEMS

Objectives

At the end of this session, the participants will be able to

- list the common health problems of women, especially those related to reproductive health.
- describe the various factors responsible for women's poor health status.

Methodology

Group discussion

Resources

- Papers/ Marker pens
- OHP and Transparencies (OHT 2.1, 2.2)
- Handout (Handout 1)

Time

150 minutes

Process

Activity 1 Group Work on Women's Health Problems through the Life Cycle (65 minutes)

- Facilitator divides participants into two groups. Depending on the situation, the allocation of the groups can be random or systematic. (30 minutes for the group task.)

Each group is asked to list

a) Common health problems that women face through different stages of life.

b) Factors responsible for these health problems.

The following format is given for presentation

Different Life Stages	Health Problems	Factors Responsible

Group presentation (15 minutes each)

- Group I presents results of the discussions, any clarifications are allowed.
- Group II presents results of the discussions, any clarifications are allowed.

Facilitator briefly (5 minutes) comments on

- Commonalities and differences in life stages, health conditions and factors responsible.
- Categorises the factors into social, cultural, gender related, economic, work related, environmental, and political.

Activity 2 Facilitator's presentation. (10 minutes)

Facilitator presents OHTs on

(a) Indicators for women's health through the life cycle (OHT 2.1)

(b) Determinants of health (OHT 2.2)

SESSION THREE: GENDER , SEX AND HEALTH

Objective

At the end of this session, the participants will be able to

- differentiate between sex and gender.
- state how sex and gender impact on health of individuals.

Methodology

- Interactive lecturette
- Quiz

Resources

- Papers/ Marker pens
- Transparencies and OHP (OHT 3.1,3.2,3.3)
- Handout (Handout 2)

Time

60 minutes

Process

Activity 1 Quiz 'Sex and Gender' (30 minutes)

- Facilitator asks the participants to state what they understand by the term 'gender' and lists the responses on one side of the board.
- Facilitator asks the participants to state what they understand by 'sex' and lists these responses in a second column.
- From the two sets of responses, the facilitator highlights the differences in the two concepts.
- Facilitator then presents OHT (OHT 3.1) and explains the characteristics of gender.
- Facilitator conducts quiz on Sex / Gender statements by reading out each statement and asking participants to say whether it is sex or gender.

Statements for the Quiz

- Women are gentle by nature.
- Men are better at playing cricket than women are.
- Women menstruate.
- Women are better cooks than men.
- Men are violent in nature.
- Women have long hair.
- Men have moustaches.
- Women are better housekeepers than men.
- Men cannot do housework.
- Men cannot control their sexual desires.
- Men get bald as they grow old.

- Women are protected from heart diseases in their youth.
- Women eat after the men have eaten their food.
- Girls play with dolls and boys with cars.
- Women have ovaries.
- Men have more hair on their bodies as compared to women.
- Women bear violence silently.
- Voice changes in boys as they grow up.
- Men are not able to look after young children.
- The body of a young girl gets more rounded as she grows up.
- Women leave their parents' house after marriage.
- Women change their names after marriage.

Activity 2 Facilitator's presentation on Gender as a System. (15 minutes)

Facilitator presents (OHT 3.2) on 'Gender as a System' while explaining each concept and asking participants for examples.

Activity 3 Facilitator's presentation on Gender and Health. (15 minutes)

Facilitator presents how differences in biological sex and gender interact to produce different categories of health conditions (OHT 3.3) and discusses the concept of gender in relation to health.

SESSION FOUR: SCOPE OF HEALTH POST AND DISPENSARY

Objectives

At the end of this session, the participants will be able to

- describe the current situation of the health post and dispensary.
- discuss the scope of health post and dispensary to provide range of services to women.

Methodology

- Discussions
- Presentations

Resources

- Blackboard, chalk
- OHP and Transparencies (OHT 4.1, 4.2)

Time

60 minutes

Process

Activity 1 Discussion on current status. (30 minutes)

- Facilitator initiates discussion on the current status of the health post and dispensary in relation to providing services for women's health problems.
- Some responses like the following will emerge:
  - Family planning
  - immunisation
  - curative services
  - condom distribution
  - Copper T insertion
- Facilitator fills in the gaps by sharing the findings of WCHP studies regarding the current status in comparison to the objectives of the facilities (OHT4.1).

Activity 2 Brainstorming. (30 minutes)

- Facilitator then does brainstorming on the range of services that should be provided at the health post and dispensary and the implications of these services in terms of resources required.
- Facilitator presents (OHT 4.2) on a desired weekly time table of the health post and discusses the feasibility in terms of implementation at the field level.

SESSION FIVE: COMMUNICATION SKILLS

Objectives

At the end of this session, the participants will be able to

- understand the process of communication.
- make an effective use of the two-way communication process.
- understand the barriers in effective communication that need to be overcome.

Methodology

- Discussion
- Role Plays
- Exercises
- Presentation

Resource

- Chart paper, pens
- Handout (Handout 3)
- OHP and transparencies (OHT 5.1, 5.2, 5.3, 5.4)

Time

120 minutes

Process

Activity 1 Discussion on Who is a Good Communicator. (20 minutes)

- Facilitator tells the participants to recall an individual who is a good communicator. Ask participants to share the recalled person's abilities or qualities as a good communicator. Facilitator writes the responses on the black board.

Possible Responses are

- Clear speech
- Easily understood language and terminology
- Ability to express ideas and feelings clearly
- Respect for the other person
- Positive attitude
- Non judgmental
- Open and broad minded, frank
- Good listener
- Sensitive to the person
- Knowledgeable
- Friendly
- Showed interest

- Facilitator summarises that a number of qualities together make a good communicator. One quality common to all good communicators is their ability to convey the message effectively to the receiver. Qualities like sincerity and empathy are always associated with effective communication

Activity 2 Exercise on Active Listening. (20 minutes)

- Make two groups and name them ' Copper T and Mala D'.
- The facilitator announces that each member of the Group Copper T will pair with a member of the group Mala D. Each member of Copper T will narrate a very happy event in his/her life to the member of Mala D.
- Facilitator then takes all Mala D members out of hearing of Copper T members and instructs Mala D members that while the person in Group Copper T is narrating the incident - for the first five minutes - do not pay attention towards what she/he is saying, interrupt or be pre-occupied. For the next five minutes, listen with attention.
- The facilitator announces the commencement of the exercise and lets it proceed for 10 minutes.
- Facilitator then asks how members of Group Copper T felt. The facilitator helps them to reflect on their feelings during the first five minutes, next five minutes; how they felt when they were not being listened to and how they felt when they were being listened to with attention.

  Group Copper T members will generally express feeling hurt, angry and helpless when the Mala D members did not listen to them carefully. These feelings are accentuated because they were talking about something personal in their lives. Then the facilitator lists out the action or behaviours that indicate active listening eg eye contact, saying "uh-hun", "I-see", leaning towards the person who is talking to you, nodding of head, not interrupting, allowing the person to finish and then checking out whether what the person is saying is understood.
- Listening to the person with attention, encourages him/her to share information, and promotes warm and close relationships.
- Facilitator also asks Group Copper T members how they felt about the non-verbal communication or body language of their Group Mala D partner, like looking disinterested, and lack of eye contact. The facilitator relates this to the situation with the patient. Also, though the client may not express much in words, a frown on the face, or hunched shoulders convey a lot.
- Facilitator summarises with OHTs 5.1, 5.2.

Activity 3 Exercise on Communication. (30 minutes)

- Facilitator instructs the participants to close eyes and recollect five people they met yesterday and write down what they said to them.
- After five minutes, the facilitator asks the participants to read out what they have written. Generally, it happens that they write and remember more of what they themselves said than what they heard.
- Facilitator explains that one tends to remember what you said to people. Most of the time one does not remember what others said because many times messages are transmitted but not listened to.
- Facilitator summarises with OHT 5.3.

Activity 4 Role Play on Patient- Doctor Communication. (60 minutes)

- Facilitator asks for two volunteers from the group. They are asked to do a Role Play in which following situation is described

> A patient comes to the health post to ask about her missed period. There is lot of noise around while the staff is going in and out of the room. The doctor is talking to two or three people simultaneously. The patient has to explain things again and again. The doctor uses English words in her questions.

- Facilitator discusses barriers to communication with reference to this Role Play and with the help of (OHT 5.4.)

SESSION SIX: COUNSELLING SKILLS

Objectives

At the end of this session, the participants will be able to

- describe what counselling is and what it is not.
- state the clients' rights in a counselling situation.
- identify qualities and skills of a counsellor.
- begin to practice some specific skills of counselling.

Methodology

- Brain storming and Discussion
- Exercises
- Role plays

Resources

- Black board and chalk
- Hand out (Handout 4)
- OHP and Transparencies (OHT 6.1, 6.2, 6.3, 6.4, 6.5)

Time

120 minutes

Process

Activity 1 Brainstorming on Concept of Counselling. (15 minutes)

- Facilitator brainstorms with the group about the concept of counselling.

The possible responses are

- Advising
- Telling them what to do
- Giving information
- Exchange of ideas
- Motivation

- Present OHT 6.1 on definition of counselling and steps in counselling. Facilitator then presents OHT 6.2 on errors in counselling.

Activity 2 Discussion on Clients' Rights. (20 minutes)

- Facilitator then presents OHT 6.3 on Clients' Rights. A discussion is generated on what actually happens at the health posts and dispensaries. Feasibility of operationalisation of these rights at that level and possible difficulties are discussed.
- Facilitator then lists down concrete steps with the help of participants on operationalisation of the Clients' Rights at the health posts and dispensaries.

Possible responses for concrete steps for operationalising Clients' Rights

- Ensuring privacy
- Providing curtains for windows
- Separate place for counselling
- Ensuring confidentiality
- No discussion with staff about clients
- Providing complete and accurate information required
- Give options to clients to make informed decision
- No motivation of clients on the basis of targets that need to be achieved

Activity 3 Discussion on Skills of Effective Counselling. (25 minutes)

- Facilitator asks the participants to list qualities and skills of effective counselling. Then OHT 6.4, 6.5 are presented to summarise these skills with relevant examples.

Activity 4 Role Plays on Counselling Skills. (60 minutes)

- The facilitator divides the participants into three groups. Role Play situations are given to the participants to practice the skills of counselling. The Role Play situations are
  - A woman comes to health post with missed periods.
  - An adolescent girl coming with white discharge.
  - A woman comes with Copper T complications.
- Skills to be emphasised
  - Active listening
  - Effective speaking
  - Asking open-ended questions
  - Reassurance
  - Empathy
  - Summarising
- Role Plays are presented. Each is discussed. Facilitator summarises the session by reinforcing
  - What counselling is
  - Steps in counselling
  - Clients' rights
  - Macro/micro skills in counselling
  - Qualities of a counsellor

SESSION SEVEN: MENSTRUAL PROBLEMS

Objectives

At the end of this session, the participants will be able to

- understand what menstruation means to women and be able to clear myths and misunderstandings associated with it.
- describe the various types of menstrual problems, their causes and clinical features.
- differentiate between the physiological and pathological variants of the menstrual problems.
- diagnose and manage some of the menstrual problems at the health post and dispensary.
- impart information and provide counselling to the women.

Methodology

- Lecture
- Group discussion on case studies
- Presentations on role plays

Resources

- OHP and Transparencies (OHT 7.1, 7.2, 7.3)
- Handout (Handout 5)
- Copies of case studies

Time

150 minutes

Process

Activity 1 Lecture on Menstrual Problems. (60 minutes)

- Lecture/discussion on the clinical features and management of menstrual problems.

Activity 2 Role Plays on Management of Menstrual Problems. (90 minutes)

- Facilitator divides participants into three groups. Each group is given a case study for discussion and presentation. Then the facilitator explains that the presentations of the role plays will include the clinical and social aspects of menstrual problems along with application of counselling skills (45 minutes).
- Group present role play. Each group presents their analysis. Facilitator invites members of the other two groups to add their analysis. Facilitator reinforces the analysis as mentioned in boxes.
- Facilitator ends session by summarising gender issues in menstruation.

Case Study 1

A 25-year-old married urban woman who runs a bookstall with her husband complains of severe pain during menstruation. She has been having this problem for two-three years. She also complains of excessive bleeding since the last 7-8 days.

Instructions

Discuss the above case focussing on history taking, examination and management. Do a presentation in the form of a role play or explain using a flow chart about how you will handle the case.

Facilitator's analysis and conclusion should cover the following points

- Menstrual history
- History of MTP, abortions
- History of contraceptives
- Internal examination
- Explain about treatment
- Follow up

Case Study 2

A 30-year-old woman complaining of excessive bleeding for the last one year comes to you for consultation. She also has an irregular menstrual cycle and has been bleeding at short intervals. She has to change her pad 6-7 times in a day and has been using an IUCD for the last one year.

Instructions

Discuss the above case focusing on history taking, examination and management. Do a presentation on how you will go about handling the case using a flow chart.

Facilitator's analysis and conclusion should cover following points

- Menstrual history
- History of contraception
- Internal examination
- Investigation of haemoglobin
- Explain about cause and treatment
- Follow up

Case Study 3

A 16-year-old girl studying in class X complains of irregular menstruation. She attained menarche when she was 14. At times she gets her menses after two months, and at others after 15 days. Her bleeding lasts for 7-8 days. She has severe abdominal pain because of which she is unable to attend school. Her exams are round the corner. She is very tense about appearing and clearing them.

Instructions

Discuss the above case to be presented in the form of a role play focussing on imparting information and counselling.

Facilitator's analysis and conclusion should cover following points

Information and counselling should focus on

- Reassurance
- Explain about menstrual cycle
- Explain about cause of pain
- If unbearable, give painkiller

SESSION EIGHT: PREGNANCY AND ANTENATAL CARE

Objectives

At the end of this session, the participants will be able to

- conduct an antenatal examination.
- detect high-risk pregnancies and refer them to the maternity home at the earliest.
- give information and counsel a pregnant woman.

Methodology

- Lecture
- Group discussions on case studies
- Presentations of role plays

Resources

- OHP and Transparencies (OHT 8.1, 8.2, 8.3, 8.4, 8.5, 8.6)
- Handout (Handout 6)
- Pens
- Copies of case studies

Time

150 minutes

Process

Activity 1 Lecture on Antenatal Care. (60 minutes)

- Lecture/discussion on the on clinical features and management of pregnancy and ANC.

Activity 2 Role Plays on ANC. (90 minutes)

- Facilitator divides participants into three groups. Each group is given a case study for discussion and presentation. The facilitator explains that the presentations of the role plays will include the clinical and social aspects of pregnancy and ANC along with application of counselling skills (45 minutes).
- Groups present role plays. Each group presents their analysis. The facilitator invites members of the other two groups to add their analysis. Facilitator reinforces the analysis as mentioned in boxes.
- Facilitator ends the session by asking the participants to list gender issues in pregnancy and ANC. Some examples are: Mother-in-law's control over the pregnant woman's food, violence by the partner, and lack of

Case Study 1

A woman who has missed two consecutive Copper T periods comes to you. She has been married for six months and her family consists of her parents-in-law and her brother-in-law. Her husband is the only earning member of the family and he earns a living selling plastic toys at the railway station. The woman is frail and complains of vomiting and giddiness. She is found to be pregnant on examination and is referred to the antenatal OPD.

Instructions

Discuss the above case focussing on history taking, examination and investigation and management. Present to the group how you will go about the process using a flow chart.

Facilitator's analysis and conclusion should cover the following points

- History taking to focus on
  - If anaemic
  - Any other illness
  - History of contraception
- Investigations
  - Haemoglobin/VDRL/ urine / blood group
- Importance of institutional delivery
- Early registration / check up
- Diet
- Hygiene
- Immunisation / supplementation iron / calcium

Case Study 2

A woman registered for antenatal care comes for her third visit. She is six months pregnant. She lives with her husband and three children. Her husband is a manual labourer. On examination you find that her blood pressure is 130/90.

Instructions

Discuss the above case focussing on examination, investigation, management, counselling and giving her information.

Facilitator's analysis and conclusion should cover following points

- Anaemic
- Advice on salt restriction
- Sleep in left lateral position
- Adequate rest
- Regular blood pressure check up
- Explain that this is a high risk factor
- Inform immediately if blurring of vision and excessive perspiration

Case Study 3

A primigravida woman is registered for antenatal care. The woman is not literate and she lives with her husband in a nearby slum. What information and advice will you give this woman before she leaves the OPD?

Instructions

Focus on making the session interactive and responding to a woman's information needs. Present this in the form of a role play.

Facilitator's analysis and conclusion should cover the following points

- Explain need for early registration and regular check ups
- Adequate rest
- Diet
- Iron and calcium supplement
- Immunisation
- Personal hygiene
- Care of breasts
- Report any unusual change

SESSION NINE: LEUCORRHOEA, REPRODUCTIVE TRACT INFECTIONS (RTIs), SEXUALLY TRANSMITTED INFECTIONS (STIs)

Objectives

At the end of this session, the participants will be able to

- differentiate between physiological and pathological leucorrhoea
- describe the various causes of leucorrhoea, RTIs, and STIs
- describe of the social and gender factors affecting RTIs
- diagnose and treat leucorrhoea, RTIs, and STIs
- counsel the patients and their partners.

Methodology

- Lecture
- Group discussion on case studies
- Presentations on role plays

Resources

- Paper/Pen
- Handouts (Handout Leucorrhoea 7, RTI 8, STI 9)
- OHP and Transparencies (OHT 9.1 to 9.8)
- Copies of case studies

Time

210 minutes

Process

Activity 1 Lecture on Management of Leucorrhoea. (60 minutes)

- Lecture/discussion on the clinical features and management of Leucorrhoea, (OHT 9.1 to 9.5, 9.8)

Activity 2 Lecture on Management of STIs. (60 minutes)

- Lecture/discussion on the causes of clinical features and consequences of sexually transmitted infections and management (OHT 9.6, 9.7, 9.8)

Activity 3: Case analysis through Role Plays. (90 minutes)

- The facilitator divides the participants into three groups. Each group is given a case study for discussion and presentation. The facilitator explains that the presentations of the role plays should include the clinical and social aspects of leucorrhoea, RTIs, and STIs along with application of counselling skills (45 minutes).
- Groups present role plays. Each group presents their analysis. The facilitator invites members of the other two groups to add their analysis. Facilitator reinforces the analysis as mentioned in boxes.
- Facilitator ends session by asking participants to list gender issues in leucorrhoea, RTIs and STIs.

Case Study 1

A 16-year-old girl comes with her mother to the health care facility. Her mother tells you that she is having excessive white discharge. The discharge is thin, watery and has no smell. There is also itching. The white discharge has been coming for the last six months just before the menses. The girl has stopped attending school as she failed in the exams. Nowadays she stays at home and helps her mother. Ever since she started staying at home, her menstrual cycle is normal.

Instructions

Discuss the above case and present it in the form of role play focussing on history taking and imparting information and counselling.

Facilitator's analysis and conclusion should cover following points

- **History taking**
  - Amount of discharge (number of pads)
  - Does she feel breathless / tired (Anaemia)
  - Any urinary symptoms
  - Bowel movements
  - Worm infestation
- **Information and Counselling**
  - Reassurance
  - Personal hygiene
  - Drinking plenty of water
  - Advice on nutrition for anaemia
  - Treatment
  - Follow up after 15 days

Case Study 2

A 25-year-old married woman with two children complains of white discharge. She has been having this problem for the last two months. The discharge is greenish yellow and has a foul smell. The woman has been using Copper T for the last four months and is also complaining of severe itching.

Instructions

Discuss the above case focussing on history taking, examination and investigation. Do a presentation on how you would go about handling the case.

Facilitator's analysis and conclusion should cover following points

- **History taking**
  - White discharge whether before or after Copper-T
  - Cu T should not remove immediately - treat and then remove if not cured
- **Examination**
  - Internal examination
- **Investigations**
  - Haemoglobin/Urine
- **Information and Counselling**
  - Partner treatment
  - Use of condom

Case Study 3

A woman investigated for leucorrhoea comes with her investigation report. Her report shows the presence of gonococci. The woman is illiterate and has four children. Her husband is a construction worker who stays away from home for days. She does not know if her husband has any health problems

Instructions.

Discuss and do a presentation in the form of a role play as to how you will tell her the diagnosis and treatment. Discuss the information that you will give her in detail.

Facilitator's analysis and conclusion should cover following points

- Information on diagnosis
  - Explain about gonorrhoea and that it is curable
  - Ask if partner has any ulcers
  - Explain about partner treatment
  - Need for follow up in 15 days
  - Use of condom

SESSION TEN: CHILDLESSNESS

Objectives

At the end of this session, the participants will be able to

- describe the causes and management of childlessness.
- understand social and gender aspects of childlessness and how childlessness affects men and women differently.
- do basic evaluation of the childless couple before referring them to a higher level.
- do counselling with the childless couple.

Methodology

- Lecture
- Group discussion on case studies
- Presentations on role plays

Resources

- Handout (Handout 10)
- OHP and Transparencies (OHT 10.1 to 10.6)
- Copies of case studies

Time

150 minutes

Process

Activity 1 Lecture on Management of Childlessness. (60 minutes)

- Lecture/discussion on the on clinical features and management on childlessness

Activity 2 Case analysis through Role Plays. (90 minutes)

- The facilitator divides participants into three groups. Each group is given a case study for discussion and presentation. The facilitator explains that the presentations of the role plays should include the clinical and social aspects of childlessness along with application of counselling skills (45 minutes).
- Groups present role plays. Each group presents their analysis. The facilitator invites members of the other two groups to add their analysis. Facilitator reinforces the analysis as mentioned in boxes.

Case Study 1

A 28-year-old woman who has been married for the last six years has been unable to conceive. Her husband is working in an office as a manager while she is a schoolteacher. Her family members are constantly abusing her. She had one MTP done five years ago.

Instructions.

Discuss the above case focussing on history taking and further management. Present to the whole group how you will manage the case in the form of role play.

Facilitator's analysis and conclusion should cover following points

- History taking about MTP
- Menstrual history
  - Painful
  - Irregular / irregular periods
  - Amount of bleeding
- If undergone any investigation
  - D & C scopy ovulations studies - ultrasound D & C
- If husband's semen analysis is done
- Reassurance
- Proper referral

Case Study 2

A couple comes to the health care facility. The semen analysis report shows that the sperm count is 5 million per ml. The man is working in a bakery and the couple has been married for three years. Initially the man was not smoking or drinking but for the last one year he has become a heavy smoker and drinker.

Instructions.

Discuss the above case focussing on imparting information, counselling and further management.

Facilitator's analysis and conclusion should cover following points

Information and counselling

- Explain about male causes of childlessness
  - Low sperm count
  - Heat
- Explore possibility of change in nature of job
- Explain about effect of drinking / smoking on fertility

Case Study 3

A woman who has been unable to conceive for the last two years comes to the health post and dispensary. You ask her to bring her husband with her. Her husband refuses to come initially but finally the health care worker is able to convince the husband to come to the health post.

Instructions.

How will you explain and motivate the husband to undergo examination. What clinical evaluation and investigation will you advice? Present this in the form of a role play

Facilitator's analysis and conclusion should cover following points

- Male factors for childlessness
  - Obesity
  - Fatigue
  - Alcoholism / smoking / tobacco/ drugs
  - Anxiety and apprehension
  - Nervousness about ability to perform sexual act appropriately
  - Information on sperm count test
- Explain about conception and thus the need for both partners to get examined

SESSION ELEVEN: CONSULTATION PROCESS AND COMMUNICATION WITH WOMEN

Objectives

At the end of this session, the participants will be able to

- understand the process of consultation.
- apply the skills of counselling and communication to this process.

Methodology

- Lecture
- Discussion on cases

Resources

- OHP and Transparencies (OHT 11.1 to 11.4)
- Handout (Handout 11)

Time

120 minutes

Process

Activity 1 (120 minutes)

Lecture/discussion on different aspects of the consultation process. For example, general guidelines for history taking ensuring privacy, using local terminology, using open ended questions, believing the woman- how to approach sexual history given the cultural context, ensuring woman's comfort and demonstrating respect during examination and so on. The contents of Handout 11 can be used as a guide. Participants can also be asked to give relevant examples of 'good practice' from their experience.

SESSION TWELVE: FIELD TRAINING

Objectives

At the end of the field training, the participants will acquire skills in

- history taking
- examination
- diagnosis
- management
- communication skills

Methodology

·The facilitator organises field training for the participants in Gynaecology and Antenatal OPDs at the maternity home/secondary or tertiary hospitals.

For the field training of STI cases of men, the facilitator sends the participants to the Skin OPD of the secondary or tertiary hospital.

Resources

- Guidelines for trainees and trainers (Annexure 2.1)
- Observation checklists for four selected conditions (Annexure 2.3)

Time

Five days (20 hours)

Process

- Make a batch of seven doctors
- Training venue -- Gynaecology Department and Skin Department of the hospitals
- A guideline will be provided to both the trainers and the trainees to ensure that all the aspects are covered during the training.

An observation checklist will be used to evaluate whether the participants have grasped the requisite knowledge, attitudes, and skills.

All the participants being trained will have to individually attend to the following number of cases

- Menstrual problems: Six
- Sexually transmitted Infections: Six
- Leucorrhoea: Six
- Childlessness: Six
- Antenatal care: Six
- Pap smears: Six
- Examining wet mount microscopy: Six

SESSION THIRTEEN: FEEDBACK ON FIELD TRAINING

Objectives

- To find out from the participants whether the field training was useful, adequate in duration, any problems faced and suggestions for improvement
- To assess knowledge and attitudes after the field training

Methodology

- Discussion
- Filling up of the format

Resources

- Blackboard, chalk
- Evaluation of field training (Annexure 2.6)

Time

120 minutes

Process

- The facilitator initiates the discussion to find out the usefulness of the training programme: problems faced and suggestions for improvement
- Then the participants fill the field training evaluation format

SESSION FOURTEEN: POST TEST

Objectives

- To assess the knowledge and attitude of the participants after the training

Methodology

- Administration of a schedule containing questions and case studies

Resources

- Post test schedule (Annexure 2.4)
- Session evaluation format (Annexure 2.5)

Time

70 minutes

Process

- The facilitator administers the post test schedule to be completed in one hour to assess knowledge, skills, and attitudes after the training
- Then the participants in 10 minutes fill the session evaluation format

SECTION III
Handouts

Handout 1

UNDERSTANDING WOMEN'S HEALTH

Contents

- Introduction
- Constraints Faced by Women Seeking Health Care Services
- Stress Factors in Women's Life
- Reproductive Health
- RH Situation in India
- Elements of Integrated Reproductive Health Services

Introduction

Women in the reproductive age group (15 - 44 years) constitute 19 per cent of the total population in India. Indian culture has assigned an inferior status to women in society and discrimination against them starts right from birth -- and sometimes even before a girl is born. This discrimination is evident from the number of female foeticides, female infanticides, a higher death rate among women, lower life expectancy, lower literacy levels, higher morbidity, low levels of employment and adverse sex ratio.

Constraints Faced By Women In Seeking Health Care Services

Women's health is neglected for various reasons. At the same time women face various constraints in seeking health services

a. Discrimination against girls in terms of health care
   - Girls are taken to less qualified doctors after more delays.
   - More money is spent on the treatment of boys.
   - More timely care is given to boys.
   - Education for girls is stopped more often, so that they can help in running the households.

b. A woman is overburdened with household work, child care and fulfilling other occupational responsibilities. With the result that she spends very little time on her own health. She neglects her health problems in the early stages and health care services are sought only when severe complications arise. Many times it is the woman herself who gives low priority to her health.

c. Most clinics, especially in the public health sector, do not offer privacy to women.

d. Many women are reluctant to approach male doctors, especially if the problem is related to the reproductive system because of religious/social taboos.

   - The expenses and time incurred in travelling long distances, consultation fees and drug fees inhibit women from seeking services as they are financially dependant on their husbands.
   - Women are less aware of the existing health care facilities.

Biomedical Barriers

a. The present orientation of the public health system which lays emphasis only on maternal and child health.

b. Infrastructure is poor in terms of funding for medicines, diagnostic facilities, the quality of medicines, physical facilities (either the distance is too much or there are no workers at the primary health care level), privacy, training, and protection.

c. Quality of care is poor: doctors and medical professionals are seen as demigods, they are "very busy" and are not supposed to be questioned. So many times irrational therapy and unethical practices take place both by private practitioners and government doctors.

d. Iatrogenic factors: aseptic precautions are not taken properly at the primary health care level.

Social/behavioural Barriers

a. Social, physical and economic inaccessibility of health care. Women have no power in a male dominated society, even when it comes to physical accessibility and care.

b. Information and communication surrounding reproductive and sexual health is poor because of social taboos and a cultural denial. People and medical professionals do not freely talk about sexual and gynaecological problems.

c. Doctors are trained in the western method of medicine so they don't know local terms, local terminology, and how people talk which also creates a lot of barriers.

d. Gender and power relations in society and the medical system also reflect in the provision of health care.

Stress Factors In a Woman's Life

Economic Stress

- Inadequate food for family.
- Inadequate financial resources for basic needs like shelter and clothing.
- Inadequate financial resources to seek medical services.

Social Stress

- Low status for women in family and society.

Cultural Stress

- Oppressive interpretation of myths and stories.
- Harmful food taboos especially during pregnancy/lactation.

Occupational Stress

- Insufficient, unequal wages and earning opportunities.
- Exploitation at work - economic, physical, and sexual.
- Work overload and ignored occupational hazards.
- Migration of self/husband.

Family Stress

- Status in the family.
- Early marriage.
- Role expectations.
- Physical stress and violence.
- Sexual stress and violence.
- Inadequate food.
- Work overload.

Personal Stress

- Poor self image.
- Frustration due to unmet needs and desires.
- Anxiety/insecurity due to lack of physical safety.

Reproductive Health

"It is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (un, 1994)."

Thus reproductive health means

- a satisfying and safe sex life, free from fear of disease and free from coercion and violence.
- the capability to reproduce and the freedom to decide if, when and how often to do so, that is access to both infertility services on the one hand and contraceptive services on the other.
- reproductive choices for women and men so that people have the right to be informed and have access to safe, effective and acceptable methods of family planning of their choice.
- access to safe, confidential and affordable abortion facilities.
- safe child bearing, access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide for a healthy infant.
- access to services for the prevention and care of reproductive health problems, both gynaecological and obstetric, in a culturally sensitive manner.
- special attention to adolescents' reproductive health needs.

Table 1 RH Situation In India

		Mumbai			Maharashtra			India		
		Slum	Non Slum	Total	Urban	Rural	Total	Urban	Rural	Total
1	Antenatal Check up									
	- Antenatal check up by health professional	-	-	-	-	-	-	76.8	41.1	49.2[1]
	- Home visits by health workers during pregnancy	-	-	-	-	-	-	9.8	24.3	21.1
2	Immunisation against Tetanus to pregnant women - Two or more doses	89.8	92.7	90.6	79.4	72.0	74.9	81.9	62.5	66.8
3	Iron and Folic Acid supplementation	89.0	94.5	90.5	88.6	82.3	84.8	75.7	52.5	57.6
4	Place of delivery / births									
	- Institutional (Public + Private + NGO)	83.5	91.9	85.8	80.8	34.5	52.6	65.1	24.6	33.6
	- Assisted by doctor	73.5	87.1	77.0	67.5	33.6	46.9	55.8	23.0	30.3
	- Assisted by Nurse	12.5	6.7	10.9	10.6	10.0	12.6	17.2	9.8	11.4
	- Assisted by TBA	10.9	5.6	9.5	8.8	26.8	19.8	18.8	34.6	35.0
	other	3.1	0.7	2.5	7.1	29.5	20.8	7.6	26.6	22.4
5	Anaemia during pregnancy	-	-	-	-	-	52.6	-	-	49.7
	- Anaemia as indirect cause of death	-	-	-	-	-	-	–	19.3[1]	–
	- Deaths due to anaemia (proportion of all female deaths)	-	-	-	-	-	-	2.3[1]	-	-
	- Death due to anaemia in 15 to 44 years age group	-	-	-	-	-	-			4.7[1]
6	Women reporting abnormal vaginal discharge (ever married women)	-	-	-	–	-	30.7		-	29.7
7	Use of contraception									
	- Any modern method	-	-	-	56.7	62.1	59.9	51.2	39.9	42.8
	- Oral Pills	-	-	-	2.5	1.2	1.7	2.7	1.9	2.1
	- IUD	-	-	-	3.5	0.8	1.9	3.5	1.0	1.6
	- Condom	-	-	-	5.6	2.9	4.0	7.2	1.6	3.1
	- Female sterilisation	-	-	-	43.6	51.9	48.5	86.0	33.5	34.2
	- Male sterilisation	-	-	-	1.5	5.3	3.7	1.8	1.9	1.9
	- Any other traditional method	-	-	-	1.7	0.4	1.0	6.7	4.4	5.0
8	Knowledge about contraceptive methods									
	- Any modern method	-	-	-	99.6	99.2	99.4	99.7	98.6	98.9
	- Oral Pills	-	-	-	92.5	78.3	84.1	91.5	75.2	79.5
	- IUD	-	-	-	87.7	74.4	79.9	87.8	64.6	70.6
	- Condom	-	-	-	85.8	61.8	71.7	88.0	64.9	71.0
		-	-	-	99.2	98.8	98.9	99.3	97.8	98.2

		Mumbai			Maharashtra			India		
	- Female sterilisation	Slum	Non Slum	Total	Urban	Rural	Total	Urban	Rural	Total
		-	-	-	89.3	86.5	87.6	93.6	87.8	89.3
	- Male sterilisation	-	-	-	43.1	28.4	34.5	60.3	44.9	48.9
	- Any other traditional method									
	- Quality of care (Home visits for family planning or health services)	-	-	-	-	-	93.0	-	-	90.2
	- Health worker spent enough time	-	-	-	-	-	84.3	-	-	78.9
	- Health worker talked nicely									
9	Quality of care during most recent visit to a health facility in the public sector	-	-	-	99.0	98.8	98.8	-	-	-
	- % of women who received service they went for	-	-	-	29.5	19.5	29.1	-	-	-
	- Median waiting time (minutes)	-	-	-	96.5	95.0	95.6	-	-	-
	- % of women who said staff spent enough time with them	-	-	-	79.2	79.7	79.5	-	-	-
	- % of women who said staff talked to them nicely	-	-	-	73.5	66.3	69.1	-	-	-
	- % of women who expressed need for privacy	-	-	-	92.6	89.4	90.7	-	-	-
	- % of women who said the staff respected their need for privacy	-	-	-	67.9	74.8	72.1	-	-	-
	- % of women who rated the facility as very clean									
10	Childlessness	-	-	-	-	-	-	-	-	73.0[2]
	- Women seeking treatment at average age less than 30 years									
	- Reasons for not seeking treatment	-	-	-	-	-	-	-	-	43.0[2]
	- Expensive	-	-	-	-	-	-	-	-	41.0[2]
	- Considered not necessary	-	-	-	-	-	-	-	-	8.0[2]
	- Lack of information	-	-	-	-	-	-	-	-	3.5[2]
	- Non availability of services nearby	-	-	-	-	-	-	-	-	3.5[2]
	- No permission from elders									
11	Adolescents	-	-	-	-	-	-		-	45.0
	- Undernutrition - girls									20.0
										29.5[1]

Sources : 1. Indian Institute of Population Sciences (1998-990), ***National Family Health Survey-Round 2****, Mumbai.*

2. Gopalan, Dr. Sarala, Dr. Mira Shiva (Eds.) (2000) ***National Profile on Women, Health and Development: Country Profile India****, Voluntary Health Association of India, World Health Organisation, New Delhi.*

RH Situation In India

1. Safe childbearing access to appropriate health care services

- Inadequate antenatal services
- Immunisation against Tetanus is poor
- Iron supplementation needs to improve
- Deliveries by untrained dais in unhygienic condition are still prevalent among the rural population

2. Care of reproductive health problems (gynaecological and obstetric)

- Lack of care during pregnancy
- Lack of diagnostic facilities
- Lack of training to diagnose and treat effectively
- Lack of training for providing sensitive counselling
- Poor referral system

3. Access to safe and affordable abortion services

- Limited availability
- Poor quality
- Illegal abortions
- Misuse of prenatal diagnostic test for sex determination, increasing the number of abortions
- Denial of confidentiality
- Forced to accept IUCD or sterilisation
- Total lack of active involvement of husband / male partner in family planning programmes
- Total neglect of emergency contraception

4. Childlessness

- Poor health care services that do not provide access to reliable information, sympathetic counselling and services to childless couples
- Poor referral system
- Lack of uniform protocols for childlessness management

5. A safe sex life, free from the fear of disease

- Poor access to information on STIs
- Poor partner identification, treatment of male partner

6. Access to safe, effective, affordable and acceptable methods of family planning and their choice

- Cafeteria approach not being followed
- Emphasis on female sterilisation
- Many women below 30 remain unprotected
- Awareness about non-terminal methods is poor and correct knowledge about use is worse
- Male involvement is weak
- Poor, impersonal, threatening or even unavailable health services
- Only prospective acceptors are told about methods considered appropriate
- Services lac k sensitivity to the needs of a woman. An average woman faces constraints in seeking services, in voicing fears and side effects and does not enjoy the right to have complete pre-acceptance counselling. She does not receive adequate information on potential side effects and complications and post- acceptance follow ups

7. Special attention to adolescents, especially girls

- Girls are vulnerable and neglected
- They come under purview of government programmes only when they are pregnant
- Majority of the girls are dropouts from school, so do not come under purview of any school health or educational programme
- At the level of the family, gender disparity in health care, food intake, school attendance and child labour from an early age
- Scant attention paid to sexual information and contraceptive needs of young, unmarried men and women

8. Access to quality health care for prevention and care of reproductive health problems

Attention needs to be paid to the physical infrastructure, equipment and personnel and also on the quality of care, especially from a client's perspective. Quality care has various dimensions

- Availability of a wide range of contraceptives, MCH and other services
- Accessible, complete and accurate information about contraceptive methods including their health risks and benefits
- Safe and affordable services, along with high quality supplies
- Well trained service providers with skills in interpersonal communication and counselling
- Appropriate follow up care
- Regular monitoring and evaluation of performance, incorporating the perspectives of the clients and the beneficiaries
- Health workers are themselves poorly informed about reproductive morbidity, are insensitive in probing and recognising symptoms and are pre-occupied with meeting contraceptive targets rather than offering a range of reproductive health services

Elements of Integrated Reproductive Health Services

1. Safe child bearing: access to appropriate health care services

- Immunisation against Tetanus
- Treatment for anaemia, nutritional deficiencies
- Regular check ups
- Screening and monitoring of high-risk pregnancies

2. Safe delivery: Trained Birth Attendant

- Timely transport for high-risk pregnancy cases to an appropriate health establishment
- Detection, management and referral for pregnancy, child birth complications
- Postnatal Care
  - Breast feeding - promotion and maintenance
  - Infant immunisation
  - Treatment of infection, Oral Rehydration Therapy, etc

3. Care of gynaecological health problems

- Routine diagnosis of gynaecological conditions
- Diagnostic facilities and drugs for routine conditions
- Women centred counselling
- Improving awareness about gynaecological problems amongst paramedical health workers and treatment modalities
- Appropriate referral system

4. Access to safe and affordable abortion services

- Information and counselling about legal termination services
- Expansion of services and trained abortion providers in rural areas
- Emergency contraception
- Access to affordable abortion services
- Management of complications
- Quality of services - sensitive counselling, care and confidentiality
- Voluntary post-abortion contraceptive services

5. Inability to reproduce: Childlessness

- Basic information and counselling
- Prevention and management
- Referral system, proper protocols for management of childless couples

A safe sex life, free from the fear of disease

Sex education and information
Condom promotion and distribution
Treatment, referral, and screening
Counselling on safe sex for men, on responsible sex, protection of partner from disease, violence and coercion for low risk women

7. Access to safe, effective affordable and acceptable methods of family planning of their choice

- Range of methods: temporary and permanent, male and female
- Enabling women and men to exercise informed choice of methods
- Greater attention to use of temporary methods
- Male responsibility and greater attention to male method use
- Pre-acceptance counselling, including information on methods, side effect and complications
- Safety and side effects research
- Post acceptance follow up services to deal with side effects and complications

8. Special attention to adolescents and youth

- Sex education
- Counselling on contraception and STI/HIV prevention
- Treatment of STIs
- Delayed child birth for adolescent girls
- Contraception and pregnancy termination services

9. Access to quality health care for the prevention and care of reproductive health problems

- Outreach services should be delivered in ways that are sensitive to a cultural milieu that inhibits women from expressing reproductive health needs or seeking health services
- Attention to women's information needs through cultural acceptance, media and messages
- Attention to the quality of services and provider-client interaction
- Support of viable Non Governmental Organisation service delivery models that can be used by the government

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References

Health Action Information Network (1998) **Proceedings of the 2nd Regional Consultation on Reproductive Tract Infections in Asia and the Pacific,** Philippines

Indian Institute of Health Management Research (1998), **Understanding Reproductive Health - Operationalising Reproductive Health Management Development for Reproductive Health Programme,** Jaipur.

Gopalan, Dr. Sarala, Dr. Mira Shiva (Eds.) (2000), **National Profile on Women, Health and Development: Country Profile India,** Voluntary Health Association of India, World Health Organisation, New Delhi.

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GENDER AND HEALTH

Contents

- Introduction
- Gender
- Gender Roles
- Access and Control of Resources
- Gender Implications for Women's Health

Introduction

This handout has two sections. Section 1 explains certain important concepts like Gender, Gender Roles, Access and Control of Resources. Section 2 explores the Gender Implications on Women's Health.

Gender

Definitions of Sex and Gender

Sex refers to the biological differences between men and women.

Gender refers to roles that men and women play and the relations that arise out of these roles. They are socially constructed, not physically determined.

Characteristics of Gender	
Relational	- Socially Constructed
Hierarchical	- Power Relations
Changes	- hanges over time
Context	- Varies with ethnicity, class, culture, etc.
Institutional	- Systemic

Relational: It is relational because it refers not to women or men in isolation, but to the relationships between them and how these relationships are socially constructed.

Hierarchical: It is hierarchical because the differences established between women and men, far from being neutral, tend to attribute greater importance and value to the characteristics and activities associated with what is masculine and to produce unequal power relationships.

Changes: Even though gender is historical, the roles and relations do change over time and, therefore, have definite potential for modification through development interventions.

Context: There are variations in gender roles and relations depending on the context: ethnic group, socio-economic group, culture etc., underlining the need to incorporate a perspective of diversity in gender analysis.

Institutional: It is institutionally structured because it refers not only to the relations between women and men at the personal and private level, but to a social system that is supported by values, legislation, religion, etc.

Social/Biological

- Emphasising the social does not exclude the role of biology.
- Recognition of social factors is crucial to an analysis of this inter relationship in order to identify the differential disadvantages and/or advantages for men and women's health.
- The emphasis on social factors within the gender approach does not imply the exclusion of the profound influence of the biological element. On the contrary, this perspective provides for the examination of interactions between biological factors and factors in the social environment that lead to situations of relative disadvantage or advantage for one of the two sexes.

Gender Roles

Productive: Comprises the work done by both women and men for payment in cash or kind.

Reproductive: Comprises the childbearing/rearing responsibilities and domestic tasks required to guarantee the maintenance and well-being of household members. It includes not only biological reproduction but also the care and maintenance of the persons who comprise the household.

Community Management Role: Comprises activities undertaken at the community level to contribute to the development or political organisation of the community. It is usually voluntary, unpaid work.

Men and women's Reproductive (or domestic) Roles: Include those tasks done to reproduce society, both physically and through passing on its system of values. Reproductive labour is the work done to ensure that workers can return to work the following day.

Both productive and reproductive roles are profoundly economic. Without reproductive roles, productive roles could not be carried out, or would be critically curtailed. Who generally carry out the tasks, responsibilities and activities assigned under REPRODUCTIVE ROLES? Women, of course!

However, in the formulation of the Gross National Product, the contribution that is made primarily by women to the national economy remains invisible because it is not considered "work" in the economic sense of the word. But it is seen as a part of their natural function derived from their role as reproducer of the human species.

The reproductive role is less valued socially because it is the work "of women". Many types of work in the area of production of goods and services, such as in the area of health and primary school education, have also been divided in accordance with gender roles. For example, the work of nurses and nurses aides, work for the most part carried out by women, is much less prestigious and well-paid than the work of a doctor, work that has been primarily carried out by men in Western societies. Interestingly enough, in the countries, which comprised the former Soviet Union, doctors are mostly female, and the medical profession is not a respected, sought-after profession, as it is in the West.

There is a third useful category that can be said to be derived from the other two roles: the COMMUNITY MANAGEMENT AND POLITICS ROLES. Here again, there is a division of functions according to gender and we often find that women are responsible for carrying out community (management) work (attending to sick neighbours, participating in Parent-Teacher associations, and involvement in religious activities) while men are more likely to participate as community leaders who negotiate with municipalities or other political authorities. This latter work is associated with status and is sometimes remunerated.

The Community Management Role has particular relevance for the health field. The voluntary participation of women in community activities, as health workers, active participants in vaccination campaigns (either to vaccinate their children or their animals) and as cooks in community kitchens, has been considered indispensable for the promotion of health. But this is based on one assumption: that women have free time. This, as we know, is not so. The type of community management work that women carry out is strongly associated with their reproductive role and with stereotypes that assign them certain types of work.

Women have to perform multiple roles in a single day (sometimes simultaneously). Given that reproductive roles are performed for the most part by women, multiple roles are more usually juggled by women. Maintaining this balance has consequences in terms of time management and its effects on the person's mental and physical health. This is a burden that women therefore have to bear to a greater extent than men.

The detection of gender roles makes previously unrecognised work visible. In general, in capitalist economies, only productive work, due to its exchange value, is considered "work". Reproductive work and community management work is not valued because it is considered "natural" and non-productive. This has serious consequences for women, because it means that most of their work continues to be invisible and, therefore, undervalued.

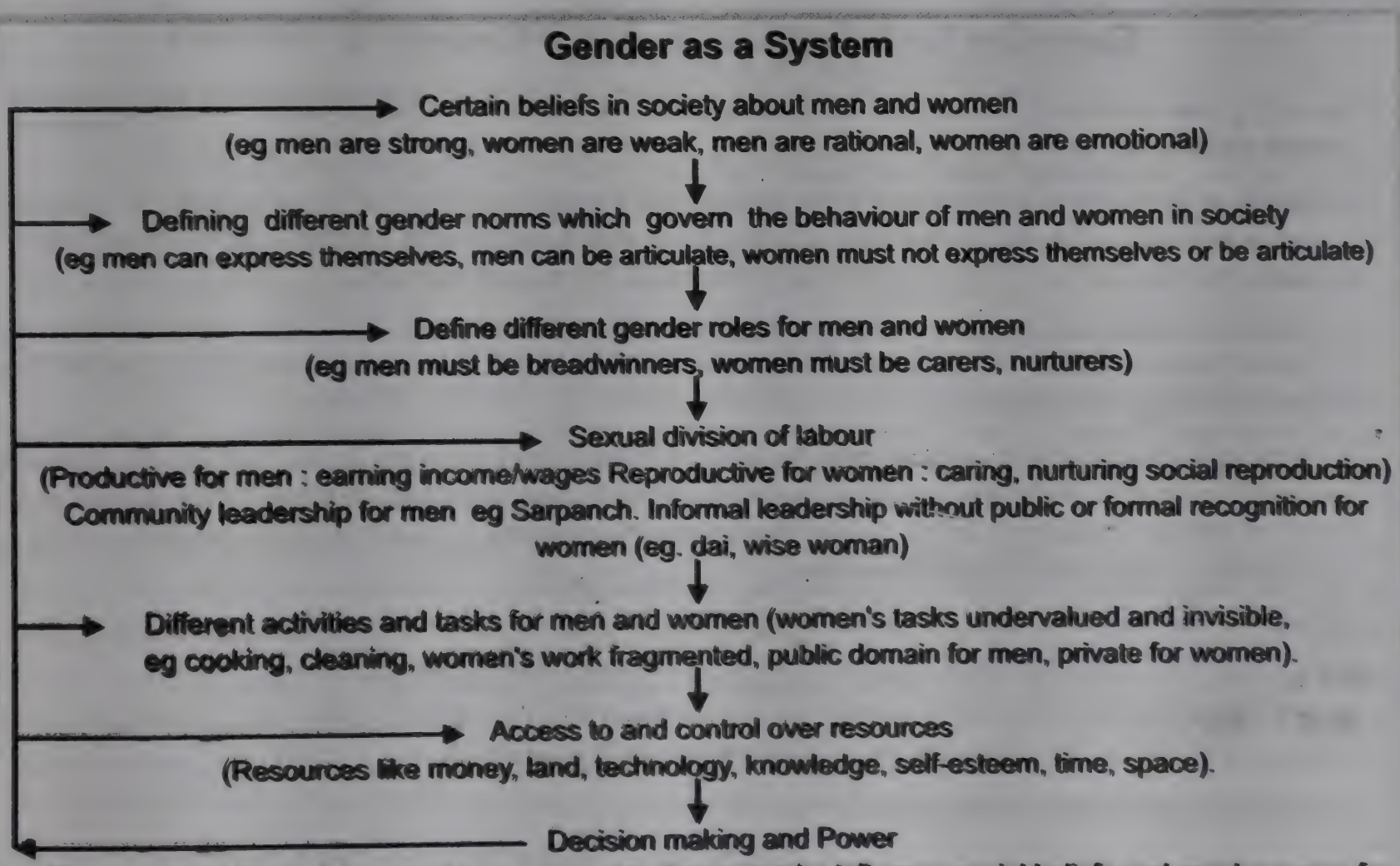
Burden of Multiple Roles on Women

Women carry out more fragmented tasks and have to divide their time between reproductive and productive tasks. The tasks of men are usually carried out in single blocks of time devoted to wage earning activities.

- It is women who are responsible for domestic tasks, although men "help" them.
- Women perform productive tasks in addition to their reproductive ones; men carry out productive tasks instead of reproductive ones.
- Women have less leisure time and more work hours than men.
- When a woman is head of a household, we see that a professional woman has to divide her time in order to perform the "male" and "female" roles in the family.
- When women leave home to work outside, other women carry out the domestic activities.
- Gender roles/relations analysis is a critical step to ensure development of gender responsive projects. It can safeguard a project from failure at best, or at the least, can minimise the degree of "harm" that is often inadvertently caused by invalid assumptions.
- Gender division of labour determines differential health risks and protective factors for men and women; therefore, planners can better respond with appropriate, varied and sustainable interventions.
- Planning that takes into account the multiple roles of women and values their work can:
  - Mitigate the economic dependence and subordination that contributes toward low self-esteem in women throughout their life cycle;
  - Significantly lessen the stress inherent in carrying out these multiple roles and the fragmentation of their tasks, increasing their leisure time, and promoting physical, emotional and mental health.

A gender approach to development can, therefore, better meet the needs of both men and women and enhance the well being of the whole community.

Gender as a System



Those who make decisions and have power are the ones who influence social beliefs and gender norms for behaviour, sexual division of labour, and access to and control over resources. Thus, this is a system, which feeds on its subsystems and perpetuates itself. The beauty of the system is that it can be broken anywhere either by changing social beliefs, or by changing norms for behaviour of men and women, or by changing the work that men and women are supposed to do, or in the allocation of resources. Thus it can be said that gender constructs can be changed over time, over space, and over contexts.

Access and Control of Resources

Definition

Access is the ability to USE a resource.
Control is the ability to DEFINE and make binding decisions about the use of a resource.

Types of Resources

Economic resources: ● Work ● Money ● Credit, etc.

Political resources: ● Position of leadership and mobilization of the actors in decision-making positions etc.

Information / education: ● Inputs to be able to make decisions to modify or change a situation, condition or problem. ● Formal education etc.

Time: ● Hours of the day available for discretionary use.
● Flexible paid work hours.

Internal resources: ● Self-esteem. ● Self-confidence.
☹ The ability to express one's own interests.

Section 2

Gender Implications for Women's Health

We tend to hear that women use health services much more than men. But that utilisation can be hindered at different times by a lack of access to and control over the different resources

In order for a woman to recognise that she has, for example, a gynaecological problem, she needs to have access to the information/education that allows her to identify the symptoms of a health problem. Access to information is a crucial element so that the woman can make the decision to go to the health services.

Even when a woman recognises that she has a gynaecological problem, she may be too embarrassed or timid to mention it to the physician. In this case, the degree of development of internal resources would give her the self-esteem necessary to take action

A woman may need to obtain medical care. However, the decision to go to the doctor might not be made by her, because she depends on the approval of her husband, mother-in-law, parents etc. At this point, the woman must have control of economic resources. In this respect, the woman must be able to cover the cost of her visit and the type of health insurance that she has could be important.

The woman may not have money to pay for transportation in order to get to the health service. Or she may not have someone with whom she can leave her children or her elderly and/or sick family members.

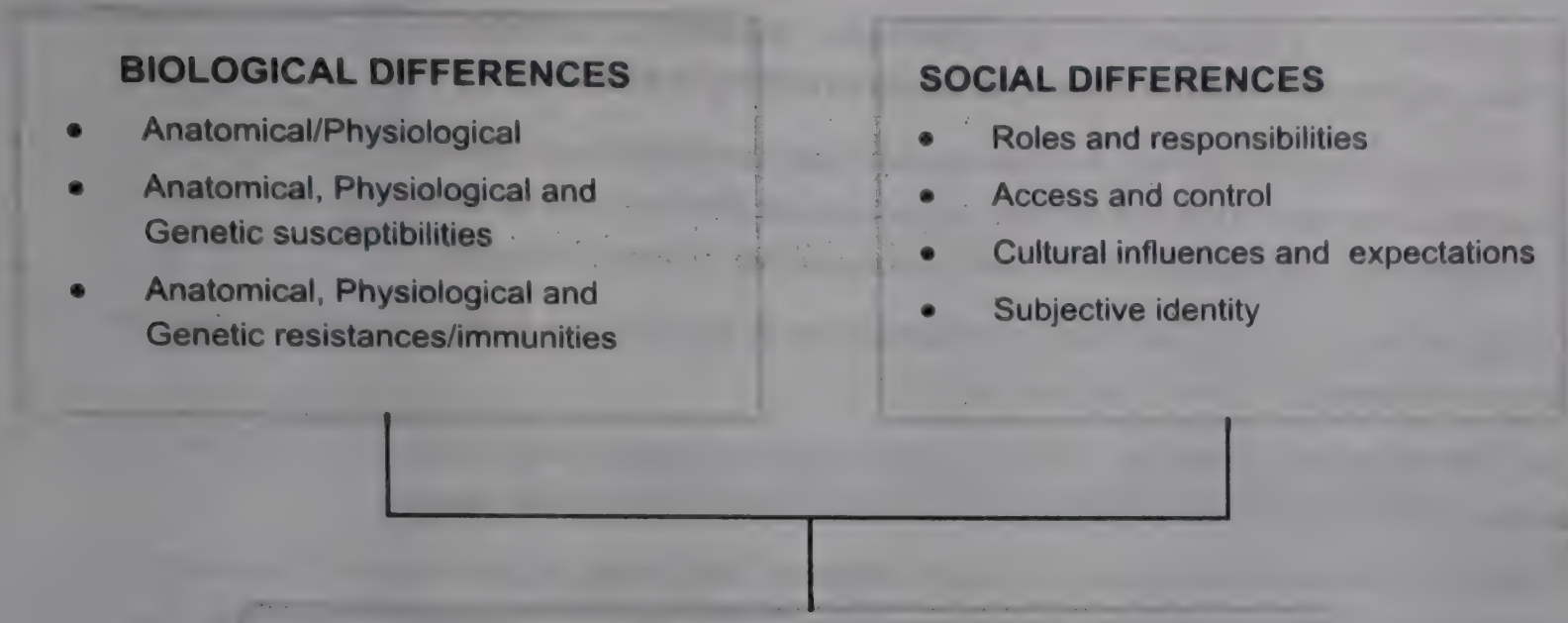
The health care service's hours, the waiting time and the travel time can constitute other obstacles due to a woman's lack of control over her time due to her reproductive responsibilities and roles.

Implications for Men's Health

Men may not have, for example, access to information on prostate cancer detection programmes. In addition, they may be informed, but may decide not to have themselves checked, due to fear or embarrassment.

A man may have control over sexual relations, but he may lack or have incorrect knowledge about sexuality and reproduction because he does not have access to adequate information. The lack of access to information can lead to sexual practices that expose both men and women to the risk of contracting sexually transmitted diseases.

ORIGIN OF DIFFERENCES IN HEALTH / ILLNESS PROFILES



*(Source : Pan American Health Organisation (1997), **Facilitator's Guide: Workshop on Gender, Health and Development,** Washington, D.C.)*

a. Different Prevalence: Situations, conditions or problems with different rates of prevalence in men or in women

Female: Anaemia due to iron deficiency, linked to women's loss of iron during menstruation, pregnancy and lactation and exacerbated by cultural practices that privilege men in intrahousehold distribution of iron-rich food; osteoporosis (8 times more in females than in males), associated not only with biological factors but also with lifestyles; diabetes, hypertension and obesity, conditions which are more frequent in women than in men, and also in lower income groups; depression (two to three times more frequent in females than in males in all phases of life, related to personality types and experiences connected with types of socialisation and differential opportunities for males and females); sexual violence in childhood, adolescence and adulthood; excessive mortality due to cancer during adult age (associated less with the lethal nature of cancers in women than with limited access to medical technologies for early detection and treatment of cancers in their initial stages); varicose veins; urinary incontinence; arthritis; autoimmune disorders.

Male: Cirrhosis associated with alcohol abuse, lung cancer associated with tobacco consumption; excessive mortality from violence, homicide and accidents; coronary heart diseases which are the biggest killers during the years that the men are engaged in labour force.

b. Different Characteristics: Situations, conditions or problems, which have different characteristics for men and for women

Sexually transmitted Infections (STIs) are "asymptomatic" for longer periods in women and have more severe consequences in women such as childlessness and even death, in cases of pelvic inflammation.

Nutritional deficiencies can cause maternal deaths in childbirth.

Alcoholism and tobacco consumption have different health consequences for women, particularly during pregnancy.

Sexual violence for women can cause unwanted pregnancy and STIs.

Malaria during pregnancy is an important cause of maternal mortality, spontaneous abortion and stillbirths; particularly during pregnancy, malaria contributes significantly to the development of chronic anaemia.

c. **Responses by Individuals/Family/Institutions: Situations, conditions, or problems with different responses from the health sector in particular or society in general**

Cardiovascular problems: the notion persists that these are typical men's diseases; as a result, symptoms are not recognised in women. Data indicate that cardiovascular diseases are one of the main causes of death, in some population groups the major cause of death, among women older than 49 years.

Disfigurement for leprosy generates greater rejection by society if the sufferer is female, given the connection between physical beauty and a woman's worth.

Very few male sterilisations are done as compared to female sterilisation (despite the fact that vasectomy is a simpler, more economical and less invasive procedure than sterilization for women).

Domestic violence toward women is judged differently from public violence against strangers and there is a greater degree of social tolerance for violence towards women from their male partners than there is for other types of social violence. This tolerance is reflected in legislation on family violence in almost every country.

Focus of family planning services on women have excluded men, with the result that men have limited access to such services. In addition, given the gender relations within a family, decisions about contraception need to include men, otherwise women can be prevented from using them by their partners/husbands.

Reference

Pan American Health Organisation (1997), **Facilitator's Guide: Workshop on Gender, Health and Development,** Washington, D.C.: PAHO

Contributor - Ms. Renu Khanna

Handout 3

COMMUNICATION SKILLS

Contents

- Introduction
- Communication Process
- Interpersonal Communication

Introduction

Human beings need to communicate all the time for some reason or other, more so health workers. They need to give or get information to persuade or influence, establish rapport with the community to reach decisions and solve problems. It is a process in which people exchange ideas, facts, feelings or impressions in ways that create a common understanding of a message. It is essentially a bridge of meaning between people.

Effective interpersonal communication (IPC) between health care providers and clients / patients is one of the most important factors for improving patient satisfaction, treatment compliance, and outcomes. If a patient is given complete information about the illness, the investigations that are to be carried out, the treatment options and when concern is shown to her, there will be greater patient satisfaction and better treatment compliance. However, very little emphasis is given to communication skills during basic Medical and Nursing training.

There is evidence of better treatment outcomes with effective communication skills. Effective communication helps to develop a rapport with the patient due to which diagnosis is accurate, compliance with treatment is better and the follow up is more regular. Thus the long-term outcome would be reduction in morbidity, mortality, and a positive health status. Effective communication helps the health system to become more efficient. It is also seen that poor provider-client communication can affect the quality of health care.

However, effective communication may not come naturally or easily. It is seen that though the health care provider and client belong to the same geographical area, there may be differences in their social status, and education and cultural background. Due to this, the message may not be interpreted correctly. Factors such as lack of privacy and time constraints also affect interpersonal communication.

It is important to understand that the styles of communication for men and women are different. Women communicate more through non-verbal, body language. Also they tend to communicate more through metaphors or symbolic forms of expressions, especially when they want to speak about their bodies. Women do not feel comfortable when talking about sexual and reproductive issues. The health care providers too are not comfortable talking about these issues in a day to day language. It is important for health care providers to develop skills required for this.

Communication styles indicate the respect that one has for others. The objective of communication should be sharing of knowledge in a way, which is understood by the woman, respecting and valuing the woman and helping her to gain control of the situation. This would be empowerment. Listening to the woman and then explaining the medical facts to her in a language understood by her is most important. Health care providers by virtue of their training tend to subconsciously use jargon while communicating with patients, which increases the feeling of inequality between the health care provider and the patient. Health care providers have to be constantly aware that they wield considerable power in their relationship with patients. Health care providers have the power of their class, education and status, as well as the power of being perceived as healers by vulnerable sick people. Effective communication will help in bridging the gap by listening to the people, empathising with them, sharing information and helping them to come to decisions related to their health. It is important to remember that health behaviour varies from person to person, one household to another and one cultural / social group to another.

The Communication Process

Components

- Communicators : Sender and Receiver
- Message : Idea to be communicated which may be verbal or non-verbal
- Channel : Audio, visual or person to person
- Barriers : Beliefs / attitudes of sender and receiver and other distracting features like overcrowding, heat, cold, noise in the room
- Effect or outcome : Changes in knowledge, attitude, behaviour

Communicator: For two-way communication, there is a sender and a receiver. The sender is the originator of the message. To be effective the sender must be clear about

- the objective of the communication
- needs, interests and abilities of the receiver
- the content or usefulness of the message and
- the channel to be used

It is important that the message is sent in the language that is understood by the receiver of the message.

Receiver has to hear the message, has to understand its content and then respond to it.

Message is the idea or information that is to be sent to the receiver. For effective communication, the message should be clear and free from ambiguity.

Channel is the medium of communication. It could be audio, visual, or both audio and visual. Communication should be adjusted to local cultural patterns and cultural media, for example, use of folklore through folk theatre, folk music and so on.

Barriers which affect communication are socio cultural gaps leading to differences in language, terminology and mannerisms, and structural factors like lack of privacy, workload, lack of sensitivity by some providers to the anxiety expressed by women undergoing examination or even during the consultation.

Effects are changes that occur in the receiver as a result of transmission of the message. eg at the end of a health education session there may be

- Changes in the receiver's knowledge - for example, when a man is provided health education on different contraceptive methods, he may have greater awareness of different family planning methods
- Changes in the receiver's attitude - the husband cited above now begins to appreciate the small family norm
- Changes in actions - the husband is now willing to undergo vasectomy instead of insisting on sterilisation for his wife

Interpersonal Communication (IPC)

This means sharing of words, feelings and communication between two or more people. Establishing a common interest or common meaning of words between two persons is the key to successful interpersonal communication. This communication must take place in close proximity ie face to face with each other and must be always a two way process.

Interpersonal communication is face to face, verbal and non-verbal exchange of information, and feelings between two or more people.

In one way communication only the sender sends the message. The receiver or the audience does not interact. An example of one way communication is a lecture. Here, it is not understood whether the receiver of the message has understood the message.

In two way communication, the sender sends the message. The receiver comprehends and understands what is being said in the message and then sends feed back to the sender. Two way communication is always better than one way communication because there is interaction between the sender and the receiver. This also allows for an opportunity to ensure that the message has been interpreted appropriately.

Reference

Women Centred Counselling in Gynaecological OPD, Women Centred Health Project, 2003

Contributor - Dr.Uma Pocha

COUNSELLING

Contents

- Definition
- Errors in Counselling
- The Client's Rights
- Components of Counselling
- Skills in Counselling

Introduction

Counselling is a process of communication, involving two or more persons who meet to solve a problem, resolve a crisis or make decisions involving personal intimate matters and behaviour.

What counselling is

There are many interpretations of what counselling is. The one which best represents the desired tone and requisite of counselling for reproductive health problems of women is "a mutual exchange of ideas, opinions, etc.; discussion and deliberation."

Counselling encourages an exchange of information as a means of clarifying and resolving problems. It should enable the client to make a decision that results in a planned action.

What counselling is not

Counselling is not telling a client what to do. A counselling session is not a question and answer period. It is not a forum for the presentation of the counsellor's values.

Errors in Counselling

- Directing
- Labelling
- Moralising, Preaching
- Giving false reassurance
- Denying client's feelings
- Encouraging dependence
- Breaking confidentiality
- Interrogating

Who is helping whom in the counselling process

Counselling is a two way process. The client, through the information, thoughts and feelings she expresses, helps the counsellor to gauge the pace, level, and intensity of the session, and thereby guides the counsellor in determining how to be most helpful.

A basic review of the communication filtering process

All of us collect and sort information all the time. Until we put the information into some sort of a framework, it has little meaning for action. The meaning of the information for you, as a counsellor, may or may not coincide with the clients or your fellow workers' beliefs, since your "filters"-- your biases, assumptions, and values – are unique to you.

The counsellor's job is to deal continually with information given and received. She must resist making assumptions and jumping to conclusions based on her filters. She should avoid comparing new information with another client's similar problem.

The Client's Rights

Accurate information on available skilled care

Clients should have access to up-to-date information.

Clients should also have access to the most skilled care available. This applies to the service provider's techniques of teaching and counselling, as well as skill in the performance clinical procedures.

Freedom of choice

Freedom of choice implies "informed choice." Therefore, clients are entitled to information that will help them make decisions. This information should be provided to them in ways they can understand.

Confidentiality and privacy

There is a great deal of medical and personal information asked from clients which is necessary in order to ensure the right kind of care. Some clients would be reluctant to provide this information without an assurance that it will remain confidential. The counsellor must see that she ensures privacy and confidentiality to the client.

Clients are entitled to privacy while they receive services. This means protection from the sight and hearing of others. Privacy extends to many aspects of care, but particularly to the clients giving of information and to the physical/pelvic examination.

Compassion, respect and understanding

Clients should always be treated with respect, regardless of their social status or way of thinking. If compassion and understanding are difficult because of cultural or religious differences between the client and counsellor, it may diminish the counsellor's ability to be objective. Differences should never be ridiculed, but explored in a quiet, non-judgmental discussion.

Components of Counselling

Counselling has both process and content components, all directed toward achieving the purpose of the counselling session, which is defined by the clients. Counselling is different from educating the client; while educating, the service provider is primarily concerned with giving information to the client.

Process Components	Content Components
• Establishing rapport • Listening and questioning • Discussion • Decision-making	• Obtaining information • Giving information

The process and content components of a counselling session are dependent on each other. The process components are more numerous, but they are dependent on content to give them substance. In a like manner, the content components depend on process for transmission.

Establishing rapport

The precise order of counselling components depends on the client's priorities and needs. Obviously, establishing or re-establishing rapport should always be done first.

A warm, friendly, non-threatening atmosphere is probably the most important factor in a first contact. This is not easy to achieve in busy, overcrowded clinics or service delivery sites, but it can be done. Creation of a friendly atmosphere should be foremost in the minds of service providers.

The counsellor should introduce herself to the client by name and title and what she does in the current setting. An exchange of a warm greeting sets the stage for interaction.

In establishing rapport, much will depend on the setting in which the meeting takes place. Can privacy for the client be assured? Can potential content of the visit be explored here and now, or should referral and follow up be planned? A group meeting is an excellent means of providing information or introducing a topic to be discussed at a later stage.

Obtaining information

First the counsellor will need to explain the services offered in the facility. Then, she may ask simple, non-threatening questions. The phrasing of these introductory questions will depend on what is culturally acceptable. For example, the counsellor may want to get the client to respond to questions such as: where do you live? how many members are there in the family? how did you hear about the clinic (the service, the programme)?

It is important to help a client become involved early in the counselling session. Gently asked questions also serve the additional purpose of focusing on the client and her needs rather than on clinic procedures.

The client's history is basic to all aspects of care, and it is most often considered a good base-line tool. A client needs to know why history taking is important, and that the information she gives will be used only in relation to the care she receives. The counsellor must simplify medical terms and should use local terminology for anatomical words and common illnesses, when appropriate. Examples might be "womb" for uterus, "high blood pressure" for hypertension, and local terms for sexually transmitted diseases.

Listening and questioning

n the process of obtaining information, the counsellor has to listen carefully to what the client is saying. One listens to content primarily, but also for hesitancy of speech and other signs of confusion. Shyness may show itself in "body language"-- not looking at the counsellor, or withdrawing from any physical contact. However, this behaviour must be carefully interpreted. In some cultures direct eye contact is considered rude and people look down, especially when talking to an older person. Fear may show itself in similar ways, or it may be more aggressive-- in denying symptoms of illness, shouting, demanding, or refusing to answer questions. Many emotions can be detected by careful listening and by watching body language or movements (non-verbal communication).

Asking questions in a counselling situation is a skill and an art. The choice of words, the phrasing of a question, the tone of voice, and the appropriateness of the content will all have an effect on the person to whom the question is addressed. Questions are a necessary part of all two way communications.

The client should always be encouraged to ask questions. Opportunities for encouraging a client to question occur throughout any contact. Counsellors can learn a great deal about a client if they are sensitive not only to what is asked, but to any anxiety or distress behind the question. Clients' questions may reveal lack of information, misinformation or apprehension.

Giving information

Giving information can be done in groups or individually. Actually, a combination of the two approaches is ideal.

A group discussion has four main advantages

- Peer group members gain support from one another because of similarity of needs.
- Clients get answers to their questions without becoming embarrassed or having to reveal their lack of knowledge.
- The teaching technique can be expanded to include discussion groups.
- It is a time saving method for staff in a busy clinic.

There are disadvantages, too

- Shy or frightened clients may be overlooked.
- Vital information may be missed.
- In some localities, there may be objection to listening to descriptions of reproductive anatomy and physiology or sexuality in what may be considered "public groups".
- Information that is misunderstood and not questioned may lead to rumours.

In an individual counselling session, giving information may be a prominent factor. The counsellor probes for information, but the client controls what information she gives. Similarly, the client may request information from the counsellor who must decide what/how information will be transmitted, eg by discussion or by booklet.

Discussion

The value of discussion is both intellectual and emotional. Doors can be opened by knowing what others think, and why. Having an opportunity to express feelings and opinions and ask for assistance with problems, help the client to take steps towards solutions.

Decision making

All components of counselling lead up to the process of decision making, the goal of the counselling effort. The decision to be made by the client may be to choose a contraceptive method. The counsellor should have patience when the client takes time to reach a decision, even if it takes days or weeks. Often, she needs time to adjust to a new idea, or she may need to talk it over with family or friends. Whatever decision is reached, it must be made freely by the client after receiving information and counselling. Client and counsellor should feel comfortable about the decision and yet "leave the door open" for future contacts.

Skills in Counselling

Macro skills of Counselling

- Clarifications: Use questions like "Did you say.....? Was it.....?" This is to ensure that you have understood the client's message correctly. It is important to ask for such feedback from the client frequently during communication with him / her.
- Asking open-ended questions: Begin questions with "Could you explain?" or "Could you tell me a little about...?" As far as possible avoid questions beginning with why, where, etc. Ask questions which will encourage the client to speak and not to give monosyllabic answers like yes or no. Do not ask directive or leading questions.
- Conveying empathy: Empathic understanding involves accurately sensing the client's world and being able to see things the way he or she does and verbally sharing your understanding with the client.
- Reassurance: The client could be agitated, depressed or anxious and the counsellor needs to reassure the client in verbal and non-verbal ways - such as "keep the faith" or "things should be fine".
- Summarising: Clients who are agitated or are in a state of shock may talk fast and about many topics The counsellor should summarise the points. This helps if it is done at the end of the session.
- Recap: Asking the client to recapitulate the information given is usually done in a concluding session, after information about an investigation or treatment procedures has been given to the client. It serves a dual purpose. One is that it gives the counsellor a chance to find out if the information has been understood by the client. Two, it helps to gauge if the client is attentively listening to the information being imparted or is pre-occupied with her own thoughts.

Micro skills of Counselling

- Paraphrasing of content: A paraphrase is saying the client's primary words and thoughts in another way. It involves selective attention and response to the client's "message content" by rephrasing it in your own words. For example:

  Client : I know I shouldn't be so hard on myself. But I can't seem to stop second - guessing whatever I do.

  Counsellor : You are aware that being critical of yourself isn't helpful, even though you haven't found a way to give it up.

- Reflection of feeling: A counsellor reflects the client's feelings in her own words. By this, it can be assured that you have understood the client accurately, and help the client to recognise her feeling too. For example:

  Client : I feel very agitated about how my husband is treating me and I really don't know how to c h a n g e him.

  Counsellor : You seen to be very angry with your husband because of his behaviour. You also seem to be worried about him.

- Appropriate use of silence: Silence in a counselling session gives the client an opportunity to reflect, integrate feelings, think through an idea or absorb new information. It is not always comfortable to allow the silence to continue, but the counsellor should not interrupt it prematurely because of his or her own discomfort. For example

  Client : How could this happen to me? What have I done to face this (begins to cry) (looking down)

  Counsellor : (silent for 10 to 15 seconds) Would you like to talk about this? (in a soft tone)

- Focussing: A counsellor should help the client to focus on his / her thoughts on the most important issue on hand. The aim of focussing is to prioritise what needs immediate attention.

  Confrontation : It is honest feedback to tell the client about inconsistencies in her behaviour, action or communication, and this needs to be completely non-judgemental. For example

  Client : I am very fond of travelling and I have travelled so many places. I know India like the back of my hand. If you have to go anywhere I can give you all the details. I know it all.

  Counsellor : Okay, now, shall we come back to your daughter's health? I think you wanted to discuss that.

What makes good counselling?

Good counselling consists of two elements

- Establishing a trusting and caring relationship with the clients
- Giving and receiving relevant, accurate information to help the client to make decisions

Qualities and Skills of a Counsellor

- Skill at reaching out
- Have goodwill and sincere interest in the welfare of others
- Warmth
- Humanness
- Sensitivity to culture
- Willing to communicate care and respect for the person you are trying to help
- Good listening skills
- Able to inspire feelings of trust, credibility, and confidence in people
- Self-respect, self-appreciation, and selfworth
- Openness to learning and growth
- Willingness to take risks, making mistakes and to admit that one has done so
- Knowledgeable about areas that are of value to the client
- Willingness to serve as a model for others
- Efficient perception of reality
- Able to understand the behaviour of others without imposing value judgements
- Able to identify self-defeating behaviour patterns and help the client change these to more rewarding behaviour patterns
- Able to reason systematically

References

Dimensions of Counselling in Family Planning (1988) **INTRAH Training Information Packet.**

Johns Hopkins University, School of Hygiene and Public Health (1987) **Population Reports Series J,** No.35, Baltimore, USA.

Contributors - Dr. Padma Shetty, Dr. Uma Pocha, Ms. Dilmeher Barucha, Ms. Bilquees Shaikh, Ms. Swati Pongurlekar, Ms. Renu Khanna

MENSTRUAL PROBLEMS

Contents

- Physiology of Menstruation
- Physiological/Pathological Variations in Menstruation
- Menstrual Problems
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- Gender Issues in Menstruation
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- Types of Menstrual Problems
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    - Primary
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  - Menometrorrhagia
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  - Premenstrual Staining and Syndrome
  - Dysmenorrhoea

Physiology of Menstruation

Menstruation represents the effects of fine interplay of gonadal and extragonadal hormones acting in concert on the endometrium in a sequential and cyclic fashion. It occurs usually about every 28 days beginning at menarche and continuing until menopause. It consists of discharge from the uterus of fragments of endometrium, blood and mucus with a mixture of vaginal epithelial cells.

Ovulation is the final event in a stepwise stimulatory mechanism starting in the hypothalamus, which contains gonadotophin-releasing cells. These produce a gonadrotophin-releasing hormone (GnRH). In the early part of the menstrual cycle GnRH induces the production of the Follicle Stimulating Hormone (FSH) by the gonadotrophs of the anterior pituitary. As a result, severe ovarian follicles start to grow during the first 4-5 days. By the 12th day of the cycle, only one follicle has reached a diameter of 1.5 cm or more. At this stage GnRH causes the secretion of the Luteinising Hormone (LH) in a surge. The combination of high concentrations of both FSH and LH induces ovulation, which escape with the ovum. Proliferation of the retained follicular cells continues. They become luteinised, forming the corpus luteum, which secretes large quantities of oestrogen and progesterone. Failing fertilisation, the corpus luteum begins to degenerate around the 22nd day and loses its functional powers. This means that there is a fall in the level of oestrogen and progesterone, which brings about menstruation. A fall in the level of these hormones also starts off a fresh positive feedback mechanism and triggers the hypothalamus to release gonadotrophs. This is how a menstrual cycle is regulated.

Physiological/Pathological variations in Menstruation

The average menstrual cycle is between 27 and 30 days and about 95 % of the ovulating women menstruate every 21 to 45 days. Therefore, if the cycle in a given woman is rhythmic (within a two to three day variation) and occurs within the interval mentioned, it should be considered normal. Bleeding intervals of less than 21 and more than 42 days or with a total absence of rhythm should be considered abnormal.

The menstrual flow usually lasts for 3 to 6 days although many women bleed for a day and a half and then have a day or so of staining. Others flow heavily for seven days, but have always done so. Such variations should not be considered abnormal.

About 30 to 100 ml blood is lost during an average menstrual period, although many women may lose two to three times this amount and still have no physical or laboratory evidence of anaemia. Bleeding that is too profuse, too prolonged or occurs at other than the usual regular interval should be considered abnormal. Irregular or extremely long intervals are significant if they occur regularly.

The degree of abnormality should be viewed in the light of the woman's age. At the time of puberty or menopause the menstrual cycle is usually irregular, in terms of the length of intervals between the periods.

The duration and amount of bleeding should remain within limits of 2 to 7 days, with the use of 4-5 pads in a day. Prolonged or excessive bleeding is abnormal and should be investigated.

A characteristic of the menstrual discharge is that it does not clot. This is due to fibrinolysis and some other factors which prevent clotting.

Menstrual Problems

Most of the menstrual disorders cannot be managed at the health post/dispensary. Some disorders like premenstrual syndrome and dysmenorrhoea can be treated at the health post/dispensary, while others need to be referred after a detailed history taking. It is important for the clinician to be able to differentiate between the physiological and pathological variations of menstruation. But if the condition is pathological the woman needs to be referred to the gynaecologist at the Post Partum Centre/Maternity Home/Tertiary Hospital.

Commonly seen menstrual problems include

- Absence of menstruation.
- Scanty bleeding.
- Excessive bleeding.
- Frequent menses.
- Prolonged intervals between menses.

Women's Perceptions of Menstrual Problems

Some menstrual problems mentioned by women during the PID study were

Irregularity of menses

"I was worried when I did not get my pali (period) for six to seven months. I was scared that people would think that I had conceived even though my husband had not come to my native place. But after taking the tablets, my period started."

"I used to get periods every 15 days."

Premenstrual problems

Vomiting, tautness of the breasts, mental irritability, stomachache, body ache, and feeling bloated are some of the commonly expressed problems. For some women these symptoms are so severe that they cannot function normally. One woman said that 15 days before the period, both her breasts hurt very badly and they hurt even if touched slightly.

Heavy Bleeding

Heavy bleeding varies from one woman to the next. For some bleeding for five days is heavy while for others, bleeding for 10 to 15 days is considered heavy. Some women also complained of blood clots during heavy bleeding.

Less Bleeding

"I get a mahina but it is not saaf. On the first day there is very little bleeding and then it stops on the second or third day."

Gender Issues in Menstrual Problems

- Suffering and endurance are generally accepted in Indian culture as part of being a woman.
- Women feel that there is no need to take treatment for menstrual problem since it is not a clinical problem.
- There is a silence surrounding menstruation, which is sustained through notions of impurity, privacy, and normality.
- Menstruation leads to restrictions and proscriptions in their lives in terms of clothing, movements and social interactions with members of the household or outsiders.
- It creates a sense of shame and disgust with one's body making a woman feel a lesser being.
- Physical segregation and avoidance reinforces inferiority in women.
- Menstruation is considered as private affair so menstrual problems are private troubles.
- Lack of information on menstruation gives women less control over their bodies.

Treatment for Menstrual Problems

Women seek treatment for menstrual problems both at government hospitals and private clinics. The most common form of treatment is the D & C procedure. In some cases the doctors also prescribe some pills. Women are categorical in mentioning any improvement that they find after the treatment.

History Taking

- Age and marital status
- Occupation
- Details of present symptoms: onset, duration, and progress
- Menstrual history
  - Menarche
  - Duration, cycle, blood loss
  - LMP
  - Pain during menstruation.
  - Past menstrual history
- Any other associated symptoms
- Obstetric history
- History of IUCD insertion
- Past history of any major illness
- History of psychological disturbances

Examination, Investigation and Management

This would depend on the type of disorder and therefore the details are not mentioned in this section. Many of the disorders need to be referred to higher levels but some of the menstrual problems can be managed at the health post/dispensary level to a certain extent. It is, therefore, essential to know about the management of these problems and when and where to refer the woman.

Information and Counselling

The following should be included in the counselling session

- Physiology of menstruation
- Causes of menstrual problems, investigations and treatment required
- Identifying the beliefs and practices related to menstruation and imparting correct information
- The implications of the examination, investigation and treatment in terms of cost, time and outcome

Referral

It is important for the clinician to know where to refer a woman. A prerequisite for this is detailed history taking.

Types of Menstrual Problems

Amenorrhoea

Amenorrhoea means the absence of menstruation. A pregnancy is the commonest cause of secondary amenorrhoea.

Amenorrhoea is of two types

Physiological amenorrhoea: When it occurs during pregnancy, lactation, before puberty and after menopause.

Pathological amenorrhoea: An absence of menstruation due to a recognisable abnormality. The pathological causes of amenorrhoea include

- Disorder of the menstrual outflow tract of the uterus.
- Disorders of the ovary.
- Disorders of anterior pituitary.
- Disorders of the central nervous system.
- Environmental stress.
- Other endocrine, systemic disturbances.

Amenorrhoea is a symptom and not a disease, but it is an indication of abnormal circumstances. A distinaction has been made between adult women who have never menstruated (primary amenorrhoea, which is a rare condition) and women who have ceased to menstruate after periods have been established (secondary amenorrhoea, which is not uncommon and has many causes).

Primary Amenorrhoea

Causes of Primary Amenorrhoea

- Congenital obstructive lesions at the lower genital tract.
- Congenital agenesis of uterovaginal canal or uterus.
- Faulty gonadal development:
  - Sex chromosome anomaly
  - Gonadal intersex
  - Polycystic ovarian disease
- Congenital adrenogenital syndrome
- Pancreas
- Hypothyroidism
- Pituitary causes
- Psychogenic
- Neurogenic
- Systemic diseases like TB, anaemia
- Nutrition: anorexia nervosa and overweight
- Certain drugs like anabolic steroids, androgens

In gynaecological practice, the criteria used in investigating the possibility of the diagnoses are

- Absence of menstruation by the age of 14 years with absence of secondary sexual characteristics.
- Absence of menstruation by the age of 16 years regardless of normal growth and development and secondary sexual characteristics.

Examination

After confirming the absence of signs of puberty the possibility of a genetic defect should be considered

- Look for the stigmata of Turner's syndrome
- Take blood to determine the genetic sex
- Test for the presence of an endocrine condition
- Request assays of LH, FSH, TSH, GH, cortisol, PSL, Testosterone, DHEA.
- Growth hormone assays are an infrequent request but should be kept in mind especially if the person is small in stature.
- Coned X-Ray Tomography (or CAT Scan) of pituitary fossa to exclude tumour.
- Examination under anaesthesia to exclude genital abnormality. In some cases laproscopy and gonadal biopsy may be required.

Treatment

Treatment depends on the causative pathology. Treatment for endocrine defects is best left to the endocrinologist. Special care must be taken to eliminate the possibility of growth hormone deficiency since such children are extremely sensitive to steroid therapy. Inexpert treatment can destroy any chance of achieving adequate growth. If menstruation is the main concern, cyclical replacement therapy with oestrogen and progesterone or cyclical oral contraception may be employed. Since not much can be done at the primary level, the girl should be referred to an endocrinologist in a teaching hospital for evaluation.

Secondary Amenorrhoea

When there is cessation of menses for three or more cycles, following a normal menstrual function, it is labelled secondary amenorrhoea. Secondary amenorrhoea is caused by pregnancy, premature menopause, drugs, endometrial TB, endocrinopathy and environmental stress.

Causes of secondary amenorrhoea

- Obstructive lesions at lower genital tract
- TB of the reproductive tract
- Uterus injuries, radiation, severe puerperal or post abortal sepsis, vigorous repeated, curettage
- Ovarian causes like premature ovarian failure, functional cysts, resistant ovary syndrome, ovarian neoplasia, polycystic ovarian disease

Management

The first is to exclude pregnancy.

If the woman does not have hirsuitism or galactorrhoea she should be given a progesterone challenge test.

Oral Medroxy progesterone acetate 10 mg is given 4 times a day for 3 to 5 days. If a woman bleeds within 7 days of the last dose of progestin, the test is positive. This means that she has a uterus primed with oestrogen from the ovaries but no progesterone, indicating that the woman has an endometrium capable of responding to oestrogen but no endogenous oestrogen is available.

The woman may either be having an ovarian failure or hypothalamic pituitary failure. FSH and LH levels are high in case of ovarian failure and low in case of hypothalamic pituitary failure. The ovarian failure may be due to premature ovarian failure, autoimmune oophoritis, pelvic irradiation, cytotoxic drugs or mumps oophoritis. If FSH and LH levels are low then the weight loss should be assessed.

Weight loss may be due to dietetic fads, anorexia nervosa or some medical disorder.

If there is no weight loss then history of stress should be found out. Stress can cause amenorrhoea. If there are no stress factors, an enquiry about the history of heavy exercise should be found out as this too can cause amenorrhoea. If there is no history of heavy exercises, then a neurological assessment is required. Panhypopitutarism, Sheehan's Syndrome, Empty Sella Syndrome, pineal gland tumour or hypothalamic tumour can lead to secondary amenorrhoea.

The cause for the oestrogen challenge test being negative could be Asherman Syndrome, genital tuberculosis and chronic endometritis. The diagnosis is confirmed by performing hysteroscopy, dilatation and curettage or laparoscopy.

Oligomenorrhoea

Oligomenorrhoea is a condition in which the menstrual cycles are prolonged to more than 35 days. In most women with this abnormality, the menstrual cycle lasts between 90 and 120 days with menstruation occurring only 3 to 4 times a year. Usually the menstrual flow is of normal duration and is not excessive. In some women, there may be profuse flow with clots on the second and third days. The prolonged interval is due to the lengthening of the pre-ovulatory phase since the post-ovulatory phase is constant (14-16 days).

Oligomenorrhoea is frequently encountered in post menarche and pre-menopausal periods and represents fluctuation in ovarian activity. It does not represent a symptom of organic disease but it requires to be investigated in cases where this pattern represents a change from previously established menstrual patterns and in patients of Childlessness.

Women in such cases should be referred to Post Partum Centre/Maternity Home.

Hypomenorrhoea

Uterine bleeding that is regular but decreased in quantity is called Hypomenorrhoea.

Management

A woman on combined contraceptive pills may get scanty withdrawal bleeding due to the effects of progesterone. A change in the pill with a lower oestrogen content will help and once the flow is satisfactory the woman may be advised to use the same contraceptive pills.

If there is no history of oral pills, then the history of the progesterone therapy in any form should be taken. If a woman is taking progestin, it should be stopped immediately.

If there is no history of progestin therapy, an oestrogen challenge test should be done. If the test is positive ie if there is satisfactory bleeding, it means that the woman is suffering from hypoestrogenism. Such a patient should be referred to Post Partum Centre/Maternity Home.

If the oestrogen challenge test fails to induce bleeding, hysteroscopy is indicated. Hysteroscopy can reveal the following conditions

- Ashermam Syndrome.
- Atrophic endometrium and fibrosis.

In such a case the woman should be referred to Post Partum Centre/Maternity Home.

In case of atrophic endometrium and fibrosis, dilatation and curettage is done to identify the cause. D & C helps in identifying the conditions of genital tuberculosis, chronic endometritis and chronic inflammation.

Polymenorrhoea

If a woman has established menstrual periods which occur every 18 to 21 days, it is considered normal for that woman.

If bleeding occurs at less than an 18-day interval it is considered abnormal and requires to be investigated. This is called Polymenorrhoea. It is common in postmenarchal girls because of fluctuations in ovarian activities. If normal, the cyclic uterine bleeding occurs at intervals shorter than the established pattern for an individual. Treatment is required if associated with childlessness.Such a woman should be referred to Post Partum Centre/Maternity Home.

Menorrhagia

Uterine bleeding excessive in both amount and duration of flow, occurring at regular intervals is called Menorrhagia. The definition of Menorrhagia is problematic since what may seem excessive bleeding for one woman, may be considered normal by another. The problem is therefore relative and should be diagnosed on the basis of a relative change from an established norm.

Management

Ask for a history of coagulation disorders to rule out a local lesion on the cervix or the vagina. Such lesions include cervical polyp, cervical adnosis, cervical ulcers, cervical carcinoma, vaginal adnosis, vaginal carcinoma, endometriosis of the rectovaginal septum spread to the posterior vaginal fornix, trauma and metastasis of a choriocarcinoma to the vagina.

Bimanual pelvic examination should be done to assess the uterine size.

If the uterus is enlarged, multinodular and irregular, the diagnosis is uterine fibroid. If the uterus is uniformly enlarged, there may be a single fibroid, adenomyosis, endometrial, hyperplasia or subinvolution of the uterus.

An ultrasonography can confirm the diagnosis. A transvaginal sonography is required to differentiate between the three types.

If the uterine size is normal, coagulation studies should be done. If any abnormality is detected in the coagulation studies, they should be treated promptly.

If the coagulation tests are normal, the thyroid status should be evaluated. Any abnormalities detected should be treated appropriately.

In case of a normal thyroid function test, D & C should be performed to determine the status of endometrium. The various abnormalities leading to Menorrhagia are

- Proliferative endometrium.
- Cystic glandular.

- Hyperplasia.
- Adenomatous hyperplasia.
- Atypical hyperplasia.
- Polyp.
- Endometrial carcinoma.
- Choriocarcinoma.
- Sarcoma.

After a detailed history and examination the patient should be referred to Post Partum Centre/Maternity Home for further treatment.

Metrorrhagia

Uterine bleeding usually excessive and occurring at irregular intervals is called Metrorrhagia.

Management

A woman receiving oral pills, injectibles or implants can have acyclic or intermenstrual bleeding. If on gynaecological examination a woman reveals no abnormality and the bleeding is occasional or mild, all that is required is reassurance. But if the bleeding is disturbing the woman, then the change of hormonal therapy is advised.

If a woman is not receiving any hormonal therapy, a gynaecological examination is required. It is essential to detect the source of the bleeding which may either originate from the uterus, cervix or vagina.

In uterine causes the blood is seen coming out of the external os. A pelvic USG reveals the cause which may be an IUCD, threatened abortion, incomplete abortion, ectopic pregnancy or a leimyomatous polyp of the cervix or endometrial polyp. In cervical factors, an erosion, polyp, adnosis or cancerous lesion may be seen. Vaginal causes are trauma to the vagina because of forceful coitus, foreign body, adenosis and carcinoma of the vagina.

Menometrorrhagia

Uterine bleeding usually excessive and prolonged and occurring at frequent and irregular intervals is called Menometrorrhagia.

Mid Month Staining

This abnormality is seen in women during the later half of their reproductive years. It consists of bleeding or spotting for a two or three day period at the time of ovulation. The woman usually complains of periods every two weeks. Diagnosis can be made by taking a careful history, supplemented by an endometrial biopsy and basal temperature chart.

Premenstrual Staining and Syndrome

Premenstrual Staining

This is the commonest form of an endocrine imbalance. The patient shows bleeding just before the onset of the expected period. There is fluctuation or a gradual decline in the level of these hormones which causes bleeding.

Premenstrual Syndrome

An average woman is aware of certain systemic changes several days before the onset of the flow. These include

- Fullness of the breasts.
- Oedema.
- Backache.
- Pain in the legs.
- A sense of depression and lethargy.

This group of symptoms has been termed menstrual molimina (molimina is a Latin word for endeavour or effort). Exaggeration of these symptoms along with a multiplicity of other symptoms for 10 to 14 days prior to menses is described as the premenstrual syndrome. The causes for premenstrual symptoms are unknown and are probably multi-factorial. The symptoms of the premenstrual syndrome are

- Swelling of the breasts and tenderness.
- Abdominal bloating.
- Craving for sweet and salty food.
- Acne.
- Asthma.
- Constipation.
- Nervousness.
- Depression and fatigue.

Management

In order to diagnose a case as one of premenstrual syndrome, the following criteria should be satisfied

- Symptoms should occur in the second half of the menstrual cycle
- At least 7 days in the first half of the menstrual cycle should be symptom free
- The symptoms should occur in three consecutive cycles and should be severe enough to require medical help

If a woman complains of breast tenderness and/or engorgement, the serum prolactin level is estimated during the symptomatic period. If prolactin levels are high, the woman should be treated for bromocriptine. If prolactin levels are normal, progestin and oral progesterone should be given.

If the symptoms do not improve after giving progestin, then the following course of treatment can be followed

- Advocate exercise
- Restricting salt, sugar and caffeine
- Vitamin B6 50-100 mg 4 times a day

If a woman complains of weight gain, spironolactone in the dose of 25 mg, 4 times a day should be given.

If a woman complains of psychiatric complaints like irritability, tension, restlessness, clumsiness, prone to accidents, sleep changes, mood swings and social withdrawal she requires psychiatric evaluation. Women suffering from psychiatric illness are prone to premenstrual exacerbations. If the results of the psychiatric evaluation are normal, then the general measures mentioned above should be followed.

Women complaining of headache may be treated with drugs like Ibuprofen or Diclofenac sodium.

Dysmenorrhoea

Dysmenorrhoea is painful menstruation and is of two types

Primary/Spasmodic Dysmenorrhoea

This is seen in girls under 25 years of age, when the pain starts one or two days before the onset of the menstrual flow. It lasts for a couple of days after the onset of the flow. The pain in Spasmodic Dysmenorrhoea is colicky and cramp like in the hypogastrium and radiating to the thighs. There is also low backache. There is no pain between menstrual cycles. Certain constitutional symptoms like nausea, vomiting, diarrhoea may be seen in some individuals.

Causes

- Obstructive factors like pinhole os/conical cervix
- Hypoplasia of uterine muscles leading to vigorous contractions to expel the menstrual discharge
- Ischaemia of uterine muscles
- Neurogenic factor
- Psychological and social factors

- Constitutional factors: impaired state of health, physical and mental exhaustion make a woman prone to conscious pain
- Endocrine factors
- Ovular menstruation with progesterone is associated with pain
- Excessive endometrial prostaglandins cause pain

Management

Bimanual pelvic examination may be necessary to rule out any pathology. If pelvic examination is normal, then it is treated as primary Dysmenorrhoea.

Bimanual pelvic examination may reveal abnormalities like irregular enlargement of the uterus, uniform enlargement of uterus, abnormal shape of normal sized uterus or retroverted fixed uterus or nodular tender uterosacral ligament. The woman will have to be referred to Post Partum Centre/Maternity Home for further management.

Secondary/Congestive Dysmenorrhoea

Secondary Dysmenorrhoea develops after the age of 25 years. It means pain associated with menstruation and is related to pelvic lesions. The causes for this could be endometriosis, chronic pelvic inflammation, uterine fibroid, cervical stenosis or due to an intrauterine device. The pain is a dull ache in the back or lower abdomen without any radiation. During the intermenstrual period, a woman may have backache and lower abdominal discomfort. Other symptoms due to the primary cause like Menorrhagia and white discharge may also be present.

Causes

- Uterine conditions like interstitial fibroid or su mucous fibroid, Adenomyosis
- Cervical stenosis
- Intrauterine contraceptive device
- Pelvic inflammatory conditions
- Pelvic endometriosis

The pain can be categorised into four groups

- Pain which starts two to three days before the menstrual flow and peaks near the end of the flow
- If bimanual pelvic exam reveals any abnormality like regular or irregular enlargement of the uterus, abnormal shape of the uterus or retroverted uterus with nodular tender sacral ligaments the patient should be referred to the Post Partum Centre/Maternity Home for further management
- If no abnormality is detected, treat as for primary Dysmenorrhoea
- The woman may complain of constant pain throughout the menstrual cycle
- If the pain worsens with the flow and bimanual pelvic examination reveals retroverted fixed uterus with tender nodular uterosacral ligament (endometriosis) or tender nodule on the side of the uterus (hemihematometia) or retroverted fixed uterus with a tender fixed mass on one or both sides (chronic PID) along with fever, the patient needs to be referred to Post Partum Centre/Maternity Home
- If the pain is relieved with the onset of menstrual flow and normal pelvic findings it suggests congestive Dysmenorrhoea
- Women with IUCD may complain of constant pain
- If the pain is associated with heavy menstrual flow and passing of clots with normal or bulky uterus, it suggests Menorrhagia. The patient needs to be referred to Post Partum Centre/Maternity Home
- The pain is severe with the passage of the endometrial casts. Here again the patient requires to be referred.

History Taking

- Age
- Marital status
- Occupation
- History of onset, character, site, duration, radiation of pain, relationship to menstrual cycle
- Any other associated symptoms

- Menstrual history: menarche, duration, cycle, loss, LMP
- Obstetric history
- History of IUCD insertion
- Past history of any major illness
- History of psychological disturbances
- Family history of Dysmenorrhoea

Examination

- General examination to detect poor health status
- Bimanual pelvic examination to detect pelvic lesions

Investigation

- Haemoglobin levels are assessed for anaemia
- Identifying the cause with investigations like sonography may be done

Management

If no abnormality is detected the following measures are adopted

- Sex education especially for adolescent girls attaining menarche
- During an attack
  - Adequate rest
  - Use of hot water bags for fomentation
  - Use of laxative
  - Personal hygiene to be maintained
- Use of drugs like
  - Tablet Combiflam, one tablet three times a day or whenever there is pain
  - Tablet Mefenemic Acid, one tablet three times a day or whenever there is pain
  - Tablet Diclofenac Sodium, one tablet three times a day or whenever there is pain
- In between painful menses
  - A course of oestrogen-progestogen oral contraceptive pills taken for six months relieves pain in more than half the cases.

References

Kistner R. W. (1986), **Gynaecology Principles and Practice,** (4th edition). Published by Year Book Medical Publisher.

Dawn C. S. (1994), **Textbook of Gynaecology and Contraceptives,** (4th edition). Published by Srhrimati Arti Dawn, Kolkatta.

Novak (1996), **Textbook of Gynaecology,** (12th edition). Published by Williams Willkinim.

Parulekar S. V. (1997), **Differential Diagnosis and Management Options in Gynaecology and Obstetrics,** (1st edition). Published by Popular Prakashan, Mumbai

BMC, LTMC & LSTM (1996), **PID Research Study** (Unpublished reports of In-depth Interviews).

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PREGNANCY AND ANTENATAL CARE

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PREGNANCY

Diagnosis of Pregnancy

Amenorrhoea

An overdue menstrual period remains for most women with a regular menstrual cycle the first suggestion of pregnancy. Pregnancy is the commonest cause of amenorrhoea but other causes such as disturbance in the hypothalamic-pituitary-ovarian axis or recent use of a contraceptive pill may also be responsible.

Occasionally a woman may continue to bleed during early pregnancy around the time of suppressed menstruation. This is usually called decidual bleeding and may, in theory, continue till about 12 weeks when the decidua capsularis fuses with the decidua vera.

Nausea or sickness

Many women suffer some gastric upsets in the early months of a pregnancy and from nausea and anorexia to repeated vomiting, especially in the morning. The cause is unknown and raised levels of both oestrogen and human chorionic gonadotrophin (HCG) in the circulation have been considered the reasons for this.

Gastric motility is reduced and in early pregnancy the lower oesophageal sphincter is relaxed.

Bladder symptoms

Increased frequency of micturition in the second and third months is due to a combination of increased vascularity and pressure from the enlarging uterus. Near term, increased frequency may again appear mainly due to the pressure of the foetal head on the bladder.

Breast changes

The earliest symptoms and signs - increased vascularity and a sensation of heaviness, almost of pain - appear at 6 weeks. By 8 weeks the nipple and surrounding areas - the primary areola - become more pigmented.

Montgomery's tubercle-sebaceous glands, which become more prominent as raised pink-red nodules on the areola.

By 16 weeks a clear fluid (colostrum) is secreted and may be expressed. By 20 weeks the secondary areola - a mottled effect due to further pigmentation - becomes prominent.

Uterine changes

Uterine enlargement may be detected on bimanual examination at 7-8 weeks.

- At 7 weeks, the uterus is the size of a large hen's egg.
- At 10 weeks, it is the size of an orange.
- At 12 weeks, it is the size of a grapefruit.

Cervical and uterine softening and a bluish discoloration of the cervix, due to increased vascularity, may be apparent. The uterus is palpable abdominally by 12 weeks and the mother may become aware of an increase in the abdominal size by 16 weeks.

The fundal height increases progressively until near term. A reduction in fundal height (lightening) may occur at the end of the pregnancy when the presenting part of the foetus descends as the lower segment and cervix prepare for labour.

Awareness of foetal movement ('Quickening')

This may be felt at 16-18 weeks in parous women and two to three weeks later in a primigravida.

Palpable uterine contractions

The uterus undergoes irregular, painless contractions from 9 to 10 weeks onwards. On an abdominal examination these may become palpable by the 20th week. Known as Braxton Hicks' contractions they become more frequent as the pregnancy advances.

Auscultation of the foetal heart

The foetal heart may be heard with a foetal stethoscope (Pinard) pressed on the abdomen, over the back of the foetus, from about 24 to 26 weeks.

Palpable foetal parts

Foetal parts, such as the head and the limbs, begin to be felt from around 26 weeks.

- The fundus is palpated and its contents identified.
- The hands palpate the contours of the uterus, identifying the back and the limbs.
- The head should be palpated and it should be noted whether it is mobile or fixed in the pelvic brim.

Confirmation of Pregnancy using an Immunological Test

Pregnancy can be diagnosed at least 8 to 14 days after missing a period.

Principles in techniques When the urine containing HCG is added to HCG antiserum, the HCG will combine with its antibody and neutralise it. If the HCG coated tanned red cells or latex particles are then added, no agglutination occurs. This is a positive test for the presence of HCG in the urine and hence for a pregnancy. If the urine does not contain HCG to which HCG antiserum is added, the antibody will remain available to agglutinate with the added HCG coated particles (tanned red cells or latex particles). Thus there will be visible agglutination and the test is negative for the diagnosis of pregnancy.

The test detects the presence of human chronic gonadotrophin in the urine. Pregnancy can thus be confirmed by doing the immunologic test with the Preg Colour Kit.

Using a Preg Colour Kit

The Preg Colour Kit contains a small test tube with a purple granule while the reagent is provided in another distilled tube. The reagent is added to the test tube containing the granule and a purple solution is obtained. Five drops of the morning sample of urine is then added to the solution. After half an hour the colour of the solution in the test tube is noted. If the solution becomes colourless the woman is confirmed as being pregnant.

The test can be done as early as three days of missing a period.

Sonography

An ultrasound scan can detect an intrauterine gestation sac after 5 to 6 weeks of amenorrhoea. Trans-abdominal scanning from 7 weeks permits a measurement of the crown-rump length of the foetus. This can be measured by determining the gestational age. Ultrasound is the only technique, which can confirm foetal viability in early pregnancy.

Antenatal Care

Systematic supervision (examination and advice) given to a woman during pregnancy is called antenatal care. This supervision should be regular and periodic in accordance with the principles laid down or more frequently according to the need of the individual. Care should start from the beginning of the pregnancy and end at the delivery.

Antenatal care comprises of

- Careful history taking and examinations (general and obstetrical)
- Advice given to a pregnant woman

Aims and objectives

The aims of antenatal care are

- To maintain the physiology of pregnancy
- To prevent or to detect at the earliest and to treat any untoward complications that may arise
- To ensure those physical defects, which are likely to become overt during the pregnancy, are detected and treated
- To improve the psychology of the mother: to remove the fear of the unknown and to educate her about the physiology of pregnancy and labour by demonstrations, charts and diagrams. The idea is to gain the woman's confidence, which will be an asset during the time of labour

- To instruct the mother regarding the general hygiene and care of the baby
- The objective of antenatal care is to ensure a normal pregnancy with the delivery of a healthy baby by a healthy mother.

The criteria of a normal pregnancy are

- delivery of a single baby in good condition between 38-42 weeks by dates,
- with foetal weight of 2.5 kg. or more and with no maternal or foetal complication.

Procedure to be followed during the first visit

As far as possible the first visit should not be deferred beyond the second missed period.

The first visit is of paramount importance in obtaining baseline information against which the subsequent changes are assessed. This baseline information helps in the determination of the gestational age.

During the first visit, the health status of the mother and foetus is assessed and screening for risk factors during pregnancy and delivery are done. This also helps to formulate the plan of subsequent management.

History Taking

- Age: Women above the age of 35 years are considered in a high-risk group. In this age group the maternal morbidity is high and maternal mortality is slightly increased due to increased complications and operative interference. Further considering the risk involved in pregnancy and labour, pregnant women in this age group are considered at high risk.
- Gravida and Parity: Gravida denotes a pregnant state both present and past, irrespective of the period of gestation. Parity denotes a state of previous pregnancy beyond the period of viability (28 weeks).

  Gravida and Parity refer to pregnancies and not to babies. As such, a woman who delivers twins in the first pregnancy is still Gravida one and Parity one.
- Duration of marriage: This is relevant when dealing with a pregnancy in a comparatively advanced age to be able to take note of fertility and fecundity. A pregnancy long after marriage without taking recourse to any method of contraception is called low fecundity and is unlikely to conceive frequently.
- Occupation: This may be helpful in interpreting symptoms due to fatigue or occupational hazards.
- Occupation of the husband: A fair idea about the socio-economic condition of the woman can be assessed by finding out about her husband's occupation. This information also helps to anticipate the complications likely to be associated with a low social status such as anaemia, toxemia and prematurity. Further a clinician can give reasonable and realistic antenatal advice depending on the socio-economic conditions of the couple.
- Complaints: The genesis of the complaints should be noted categorically stating the mode of onset, progress and duration. Even if there is no complaint inquiries should be made about sleep, appetite, bowel habit and urination.

History of the present pregnancy

Important complications in different trimesters of the present pregnancy should be noted carefully as these are hyperemesis and may threaten abortion in the first trimester, features of pyelitis in the second trimester and anaemia, toxemia and antepartum haemorrhage in the last trimester.

Obstetrical History

The previous obstetric events should be recorded chronologically.

Menstrual History

Cycle, duration, amount of blood flow and first day of the last menstruation period (LMP) should be noted. The expected date of delivery (EDD) can be calculated from the LMP. The first day of the menstruation being an important event can be remembered precisely while the last day of the period is often tailed off and hence may be forgotten.

Calculation of the expected date of delivery (EDD). The duration of pregnancy has to be expressed in terms of completed weeks. A fraction of a week of more than 3 days is to be considered as a complete week. This is done according to Naegele's formul (1812) by adding 9 calendar months and 7 days to the first day of the last period.

Alternatively, one can count back three calendar months from the first day of the last period and then add 7 days to get the expected date of delivery. However, it is the first method that is commonly employed.

Past Medical History

Relevant history of past medical illnesses like tuberculosis, hypertension and diabetes should be got from the woman.

Past Surgical History

Previous surgery - general or gynaecological, if any, has to be found out.

Family History

Family history of hypertension, diabetes, tuberculosis, blood dyscrasia, any known hereditary disease, or twinning have to be found out.

Emotional stress

A woman getting pregnant for the first time may be worried about the physiological changes occurring in her. Or a woman having only daughters may be facing abuse in the family. There is also need to find out it she faces violence.

Violence against Women as a Health Issue

According to the World Bank (1993) rape and domestic violence account for 5 per cent of the healthy years of life lost to women between 15 and 44 years in developing countries. Worldwide, gender-based violence accounts for more death and ill health than cancer, traffic injuries and malaria put together.

There is growing research that domestic violence towards a woman often begins or escalates during her pregnancy. One US study showed that 37 % of obstetric patients suffered abuse, and that 30 % of domestic violence actually started during pregnancy (Young 2003). In another USA household survey, it was found that pregnant women are 60.6% more likely to be beaten than women who are not pregnant. Violence is cited as a pregnancy complication more often than diabetes, hypertension or any other serious complication.

(Source : "Battering and Pregnancy", Midwifery Today, 19: 1998).

Physical Effects of Violence during Pregnancy

- Insufficient weight gain
- Vaginal/Cervical/Kidney infections
- Vaginal bleeding
- Abdominal trauma
- Haemorrhage
- Exacerbation of chronic illnesses
- Complications during labour
- Delayed prenatal care
- Miscarriage
- Low birth weight
- Ruptured membranes
- Abruption placenta
- Uterine infection
- Foetal bruising, fractures and haematomas
- Death

(Source : "Abuse of Pregnant Women and Adverse Birth Outcome." Journal of the American Medical Association 267: 1992).

Role of the Health Care System

NFHS 2 found a high level of acceptance of domestic violence among women. More than half (56%) of the women accept that men are justified in beating their wives, if women do not live within the socially prescribed roles. The health care system and health workers are in unique position to identify, document and respond or refer victims of violence. This is because they are the first contact point for persons who have been assaulted, as women do seek medical assistance for their injuries even if they do not disclose the violent incident. The health care providers can provide comprehensive, gender-sensitive health services to victims of violence to manage the physical and mental health consequences of the assault.

Health care providers, however, generally seem to believe that the causes of physical injuries that battered women present are not their business. They perceive their roles as limited to dressing the wounds and prescribing medicines. Some view domestic violence as a private issue and fear that clients would be upset or offended if asked directly about violence. Others do not quite know how to ask and how to respond if a woman does admit to being abused. Yet others feel that they have no time or space (within the context of overcrowded dispensaries and outpatient departments) to deal with the needs of victims of violence.

Another barrier that prevents health workers from addressing violence is that they belong to the same cultural and social milieu as their patients. They share the same values and attitudes towards abuse that are prevalent in the larger societal context. For instance, many women and men believe that a woman is the property of her husband and so an occasional beating is quite acceptable. The constructs of sexuality in many cultures define that women have to be available for sex whenever their husbands need it. Male clinicians may hesitate to accept a woman's account of violence because they identify with the offender. Women health workers who have been victims of abuse may not find it easy to discuss violence with their patients.

Another major barrier is the reluctance of doctors to get involved in legal liabilities and procedures. Lack of referral service and poor coordination between health, legal and social welfare departments also act as deterrents. Studies show that women who have been battered value direct questions about abuse, referrals to appropriate agencies that offer assistance, follow-up visit.

With training and support from health care systems, providers can respond more positively to the physical, emotional and security needs of abused women and girls. They can learn how to ask women about violence in ways that the women find helpful. They can give women empathy and support. They can provide medical treatment, offer counselling, document injuries, and refer their clients to legal assistance and supportive services. They can reassure women that violence is unacceptable and that no woman deserves to be beaten, sexually abused or made to suffer emotionally. Family planning and other reproductive health care providers have a particular responsibility to help because abuse has a major, although little recognised, impact on women's reproductive health and sexual well-being. Unless they understand how violence and powerlessness affect women's reproductive health and decision-making ability, the services they provide will not be effective

(Source : Khanna (2002), et al. ***Towards Comprehensive Women's Health Policy and Programmes)***

Examination

- General Examination
  - Build: Obese / Average / Thin
  - Nutrition: Good / Average / Poor
  - Height: A short stature (less than four and a half feet in height) is likely to be associated with a small pelvis
  - Weight: Weight should be measured in all cases on an accurate weighing machine. Repeat checking of weight on subsequent visits should preferably be done on the same weighing machine
  - Pallor: The places to be noted are lower palpebral conjunctiva, dorsum of the tongue and nail beds
  - Jaundice: The places to be noted are bulbar conjunctiva, under surface of the tongue, hard palate and skin
  - Oedema of legs: Both the legs should be examined. Evidence of oedema should be looked at over the medical malleolus and anterior surface of the lower 1/3rd of the tibia. The area should be pressed with the thumb for at least 5 seconds. Varicosity in the legs, if any, should also be noted
  - Oedema of the legs may be physiological or due to pre-eclampsia, anaemia and hypo-proteinaemia, cardiac failure or the nephrotic syndrome
  - Pulse and Blood Pressure
- Systemic Examination
  - Breast examination: Examination of the breasts is mandatory not only to note the changes because of pregnancy but also to note the nipples (cracked or depressed) and the skin condition of the areola. The purpose of this examination is to correct any abnormality so that there is no difficulty in breast-feeding immediately following the delivery
- Obstetrical Examination
  - Abdominal: Tone of the abdominal muscles, presence of any incisional scar or presence of herniation and skin condition of the abdomen should be looked for. Fundus of the uterus is just palpable above the symphysis pubis at 12 weeks
  - Vaginal: Unless contraindicated, the internal examination is done at the antenatal clinic, which the patient attends for the first time before 12 weeks. It is done to diagnose the pregnancy, to corroborate the size of the uterus with the period of amenorrhoea and to exclude any pelvic pathology
  - The examination should be done with utmost gentleness. Internal examination is, however, not done in case there is any previous history of abortion, occasional vaginal bleeding in the present pregnancy or in a specially valuable pregnancy

- Routine Investigations
  - Examination of the blood for haemoglobin estimation, determination of ABO grouping, Rh typing and VDRL.
  - Urine is examined routinely for albumin and sugar.
  - Sonography if required.

- A woman has to be referred to the upgraded dispensary if available or to the Post Partum Centre/Maternity Home for these investigations.
- Immunisation
  - Immunisation against tetanus not only protects the mother but also the neonates. In an unprotected woman, 2 doses of 0.5 ml. tetanus toxoid is given intramuscularly at 4-week intervals. Women who have been immunised in the past three years with 2 doses, are given a booster dose of 0.5 ml. IM.
- Supplementary Iron and Calcium Therapy
  - Tab. Iron Folic Acid - 100 mg per day
  - Tab. Calcium - 500 mg per day
  - During antenatal visits, if a woman is found to have any of the risk factors, she should be immediately referred to Post Partum Centre/ Maternity Home.

RISK FACTORS

- More than 35 years old.
- Height: less than four and a half feet.
- Parity: more than five.
- History of two or more abortions.

Procedure at subsequent visits (Up to the 28th Week)

Check-ups should be done at intervals of 4 weeks from the first visit. The findings on every visit should be recorded in the same card for better evaluation.

Subsequent visits help in identifying retardation of the foetal growth, preeclampsia, hydramnios or anaemia at the earliest.

History

Note the appearance of any new complaints and the approximate date of quickening.

General Examination

- The following must be noted on each visit:
- Weight
- Pallor
- Oedema of legs
- Blood pressure

Abdominal Examination

- Note the height of the fundus above the symphysis pubis and determine its relation to the estimated duration of the pregnancy. From the 20th week, the fundal length increases by about 1 cm per week. The fundus is palpable just above the symphysis pubis at 12 weeks. At 16 weeks the fundus is palpable at 1/3rd the distance of the symphysis pubis and navel. At 20 weeks, the fundus is palpable at 2/3rd the distance between symphysis pubis and navel and at 24 weeks, the fundus is palpable at the navel.
- To identify the foetus by external ballottment, foetal movements and palpation of foetal parts.
- To listen to the foetal heart sounds.

Investigations

Urine examination for albumin and sugar.

Injection Tetanus Toxoid

Ensure that the woman has completed the required doses of TT.

Supplementary Iron and Calcium Therapy

Ask the woman whether she is taking the tablets regularly. If the woman is anaemic (Hb less than 8 mg) supplement additional 200 mg of Iron Folic Acid daily.

During the antenatal visits, if a woman is found to have any of the risk factors, she should be referred to the Post Partum Centre / Maternity Home immediately.

Procedures at Subsequent visits - Beyond 28th week

Check ups should be done at intervals of 2 weeks up to the 36th week and thereafter they should be done every week till the expected date of delivery. Beyond 28 weeks, a woman is referred to Post Partum Centre/ Maternity Home for further antenatal check ups. These include

History

Note appearance of any new complaints.

General Examination

The weight, pallor, oedema and blood pressure should be recorded on every visit.

Abdominal Examination

This will help in identifying

- The lie, presentation, position of the foetus
- Foetal growth pattern
- Volume of liquor amnii
- Detection of any abnormality

The relation of the head to the pelvic brim must be noted in primigravidae if the head fails to engage by 38th week. At 28 weeks, the fundus is palpated at 1/3rd the distance between navel and xiphisternum. At 32 weeks, it reaches 2/3rds the distance and 36 weeks touches the xiphisternum. At 40 weeks, the foetus descends down and reaches the level as at 32 weeks of gestation.

A measuring tape at the level of the umbilicus measures the girth of the abdomen. The girth increases by about 2.5 cm (1") per week beyond 30 weeks and at term measures about 95 to 100 cm. (38" to 40")

Note the foetal heart sounds

Beyond 28 weeks, the antenatal visits help to confirm permanently the stable lie and presentation of the foetus and to detect at the earliest two important complications (anaemia and toxemia)

Investigations

- Haemoglobin.
- Urine examination for proteins and sugar.

Common Complaints during Pregnancy

Subjective Complaints

Fatigue, somnolence, headache and 'blackouts' are often noticed in the early months but their causes are uncertain. Hypertension, secondary to peripheral vasodilatation, may be responsible for the faint feelings.

Morning sickness

Nausea and vomiting are probably due to the effects of large amounts of circulating steroids, especially oestrogens or HCG and they seldom last beyond the 16th week. They can occur at any time of the day and are aggravated by cooking and fatigue.

Mild cases of morning sickness are treated by a light carbohydrate diet (biscuits and milk) in the morning and sometimes by anti-emetics. If the condition worsens it becomes hyperemesis gravidarum and is best treated in a hospital.

Constipation

This is due principally to the relaxing effect of progesterone on the smooth muscle. A bowel motion every second or third day is perfectly consistent with good health, but laxatives may be required sometimes. Any of the commonly used drugs may be taken with safety.

Heartburn

The enlarging uterus encourages oesophageal reflux of gastric acid. Sleeping in a semi-recumbent position is helpful. Antacids can be prescribed safely.

Haemorrhoids / Varicose Veins

Pressure from the enlarged uterus gradually obstructs venous return and may lead to haemorrhoids and varicose veins of the legs and vulva. Support tights may be helpful for leg varicosities while suppositories are used for haemorrhoids. Nothing can be done for varicosities of the vulva beyond advising the patient to rest.

Vaginal Discharge

Increased secretion of cervical mucus and the vascularity of the vagina combine to produce a fairly copious discharge during a pregnancy. This should not be offensive or itchy and ordinary hygiene is the only treatment required.

Infection with Candida albicans is a common complication. This is encouraged by the warmth and moisture of the vulva and vagina together with the increased vaginal glycogen which favours the fungus. Complaints of Candida albicans include discharge and constant irritation. A swab should be taken and the characteristic plaques of yeast may be seen. Trichomonads may also be seen. Bacterial vaginosis is said to be common during a pregnancy and may be associated with some cases of pre-term labour.

Treatment of candidial and trichomonial infection is done by using clotrimazole pessaries. This may be difficult to remove totally during a pregnancy but treatment is required to relieve symptoms and reduce the chances of infecting the foetus during its passage down the vagina.

Antenatal Advice

Principles

- To impress upon the woman and her partner the importance of regular check ups.
- To maintain or improve if necessary the health status of a woman to the optimum till the delivery by judicious advice regarding diet, drugs, and hygiene.
- To improve and tone up the psychology and to remove the fear of the unknown by talking sympathetically to a pregnant woman.
- To explain about danger signs / symptoms ie when to seek help

It is important to involve the decision-makers in her family in antenatal care. The decision-makers generally are the mother-in-law and the husband.

Diet

- During pregnancy the diet should be adequate to provide for
    - the maintenance of maternal health
    - the needs of the growing foetus
    - the strength and vitality required during labour and
    - successful lactation

- During pregnancy, a woman needs increased calories due to the increased growth of maternal tissues, foetus, placenta and increased basal metabolic rate. The increased calorie requirement is to the extent of 300 over the non-pregnancy state during the second half of the pregnancy
- Diet during pregnancy should ideally be light, nutritious, easily digestible and rich in protein, minerals and vitamins. Besides the principal foods the diet should have half to one litre of milk (1 litre of milk has about 1 gm of calcium), one egg, plenty of green vegetables and fruits
- A pregnant woman should try and eat about four times a day
- Some women avoid eating mangoes, papaya, dates and eggs, as they are considered to be 'hot' foods and hence harmful during a pregnancy. The doctor should find out whether any such advice has been given to the pregnant woman by elders in the home and try not to contradict it if it is not harmful to the woman's health
- It is found that certain food habits or avoiding certain kind of food is not going to help the woman so details about these should be found and the woman advised accordingly
- Sometimes information on diet also needs to be given to the woman's mother or mother-in-law, as these women influence her dietary habits to a large extent
- The socio-economic conditions of the woman must be kept in mind when giving advice about diet
- Food habits and individual tastes should also be kept in mind and the instructions given should be reasonable and realistic

Supplementary Iron and Calcium Therapy

Supplementary iron therapy is needed for all pregnant women from 20 weeks onwards. Pregnant women with 10 gm % of haemoglobin and above can be given 1 tablet of ferrous sulphate containing 60 mg of elemental iron. The dose should be proportionately increased with lower haemoglobin levels to 2 tablets a day.

It is useful to tell a pregnant woman about the normal haemoglobin level and her haemoglobin level, whenever it is tested. This will motivate her to keep a check on her Hb level and change her diet if necessary. Telling a woman about her Hb result will also motivate her to take IFA regularly.

- Antenatal Hygiene
  - In otherwise uncomplicated cases, the following advice should be given
  - Maintain personal hygiene to prevent infection and to take proper care of the breasts
- Rest and sleep
  - A pregnant woman may continue with her usual activities during the pregnancy. However, if she feels tired, she should limit her work.
  - Hard and strenuous work should be avoided specially in the first trimester and the last 6 weeks. Working women are entitled to maternity leave 6 weeks prior to the expected date of delivery.
  - The amount of sleep required by pregnant women varies. However, on an average, a pregnant woman should be in bed for about 10 hours (8 hours at night and 2 hours at noon) especially during the last 6 weeks.
  - It may not be possible for all women (especially for those from specific socio-economic backgrounds) to rest for 10 hours a day. Hence it is advisable to find out the daily routine of a pregnant woman and if it is found that she does heavy work like lifting water vessels, her husband and /or family members should be asked to step in so that hard and strenuous work is at least avoided in the first trimester.
- Bowel movements
  - There is a tendency of constipation during pregnancy which may be related to backache and abdominal discomfort. Regular bowel movement may be facilitated by regulating the diet and taking plenty of fluids, vegetables and milk or prescribing mild laxative like milk of magnesia or Cremaffin (pink) 4 teaspoons at bedtime or Isogel (Isabgul) 2 teaspoons at bedtime (to be taken with warm milk)
- Dental care
  - A woman should maintain dental hygiene during the pregnancy so that she does not suffer from any dental problems. Pregnant women should also avoid eating tobacco.

- Care of the breasts
  - If the nipples are anatomically normal, nothing should be done beyond maintaining ordinary cleanliness. If the nipples are retracted, they need to be corrected in the later months by manipulation or by using special syringes
- Coitus
  - Coitus should be avoided during the first trimester preferably during the time of missed periods for fear of abortion. It should also be avoided during the last 6 weeks for fear of infection and premature labour
  - Information on sex during pregnancy should be given to both husband and wife
- Exercise
  - A pregnant woman can be advised to go for long walks. Many women feel that doing housework is enough exercise, which it is not
- Travel
  - Travel by vehicles, which have jerky movements, are best avoided especially in the first trimester and during the last 6 weeks of the pregnancy.
  - Long journeys should preferably be limited to the second trimester
  - Travel by rail is preferable to travelling by bus. If a pregnant woman has to travel by bus, she should sit in the front
  - Travel in pressurised aircraft offers no risk
  - A pregnant woman should avoid travelling by auto rickshaws
- Other medications
  - Pregnant women should not take any medicines without the doctor's advice. Even simple medicines like Anacin for a headache should not be taken without consulting a doctor
  - Self-medication should be completely avoided
- Danger signs
  - A pregnant woman must be persuaded to attend antenatal check ups on the schedule dates.
  - She should also be instructed to report to the physician at an early date if some untoward symptoms arise such as intense headache, disturbed sleep with restlessness, urinary troubles, epigastric pain, vomiting and scanty urination.
- Labour signals
  - Painful uterine contractions at intervals of about 10 minutes or earlier for at least an hour suggest the beginning of labour
  - A sudden gush of watery fluid per vaginam is suggestive of a premature rupture of the membranes

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References

Dutta D.C. (1998), **TextBook of Obstetrics,** (4th edition). Published by New Central Book agency Pvt. Ltd. Miller A.W.F.

Hanretty K.P. (1997), **Obstetrics Illustrated,** (5th edition). Published by Churchill Livingstone

Women Centered Health Project, (2003), **Gatha Stree Arogyachi,** (2nd edition), BMC, Mumbai

Khanna Renu, Mira Shiva, Sarala Gopalan (Eds) (2002), **Towards Comprehensive Women's Health Programmes and Policy,** Published by SAHAJ on behalf of WAH !, Baroda

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LEUCORRHOEA

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Introduction

The normal vaginal environment is acidic. Many bacteria live harmlessly in this environment. This acidic environment prevents the growth of harmful bacteria. However, this delicate balance in the vagina can be upset due to several factors.

- Lowered resistance
- Poor nutrition
- Any major illness
- Copper Ts or abrasions
- Menstruation, pregnancy, antibiotics, oral contraceptives, other hormones, douching, diabetes, pre-diabetes and menopause which alter the vagina environment
- Sexual activity, especially multiple partners
- Unhygenic practices (not washing genitals after urinating, defecation or sex)

Leucorrhoea is the pouring out of the white discharge per vagina. Leucorrhoea or vaginal discharge is the commonest symptom of gynaecological ailments. A majority of these discharges are due to infection of the vaginal epithelium cervix and some are due to the malignancies of the cervix, uterus or vagina, to cervical ectropions erosions and to senescent changes during menopause. A small amount of vaginal discharge is normal in adult life during certain days of the menstrual cycle especially post menstrual, ovulation discharge.

Sources of Vaginal Discharge

Vulva: Greater vestibular (Bartholin's glands) glands of the vulval skin.

Vagina: Mainly desquamated epithelial cells which liberate glycogen. The lactobacilli metabolise the glycogen to lactic acid.

Cervix: Alkaline mucous secretion which becomes copious and watery during ovulation. Uterine glands also discharge into the vagina.

Defence Mechanisms to Protect against Infection

The vulva, vagina and ectocervix under normal conditions are the habitat of various types of infective agents, but they are only a threat if normal defence mechanisms are altered. The various defence mechanisms are

Vaginal Acidity

Glycogen is produced by vaginal epithelium under the influence of ovarian hormones. This is converted into lactic acid by Doderlein's bacillus (a type of B acidophilus). This maintains the vaginal pH between three and four which inhibits most other organisms.

Thick layer of vaginal squamous epithelium

This is considerable physical barrier to infection. Continual desquamation of the superficial kerato-hyaline layer and glycogen production, both dependant upon ovarian steroid action, prevent bacteria settling. In children and post menopausal patients the epithelium lacking steriod stimulation is thin and easily traumatised.

Closure of the introitus

In children and virgin adults the vaginal canal is only a potential space kept closed by the surrounding muscles and provides another physical barrier. This, however, alters and becomes of little importance with sexual activity and pregnancy.

Giandular Secretions

Giandular Secretions from the cervix and Bartholin's glands maintain an outward fluid current helping to clear the canal of debris. In addition, cervical secretion contains immunoglobulins, especially IgA, and there are varying numbers of polymorphs, lymphocytes and macrophages.

Clinical Features

The need to wear a pad or tampon continuously suggests excessive discharge. Sudden onset means infection. Onset can be associated with the end of pregnancy, the contraceptive pill, a course of antibiotic, onset of a sexual relationship. Normal discharge is white but stains yellow or pale brown. A greenish-yellow colour suggests pyogenic infection, commonly accompanied by an unpleasant odour. A red or dark brown colour suggests blood.

Any discharge can in time excoriate vulva but only candida and trichomonas cause itching. There may be chafing, soreness, burning or redness of the vagina, vulva or inner thighs.

Differentiation between Physiological Leucorrhoea And Pathological Leucorrhoea

Physiological Leucorrhoea

This means an excessive amount of normal discharge which is a very subjective assessment. The patient complains of constantly having to change her clothes, but no irritation is seen and the appearance is normal. The smell is of the normal vulva odour. Microscopy will reveal normal appearances and culture shows only lactobacilli growth. Normal secretions from the vulva, vagina and cervix show an increase in the following conditions:

- At puberty due to hormonal effects
- During sexual excitement
- At the time of ovulation
- During pregnancy

The patient should be reassured and given an explanation of normal physiology. No local treatment is necessary.

Pathological Leucorrhoea

The various causes of pathological leucorrhoea can be divided into the following.

General Ill health

- Undernutrition
- Dysfunctional (marital disharmony, endocrinal and psychosomatic illness)
- Psychological

Infective causes

- Candida albicans
- Gardnerella vaginalis
- Trichomonas vaginalis
- Gonococcal infections
- Non-gonococcal infections

Non Infective causes

- Cervical erosion
- Chemical irritants, foreign bodies
- Cervical carcinoma
- Uterine tumours
- Genital prolapse
- Contraceptives

A majority of the patients attending gynaecological clinics complain of vaginal discharge of which about 20 % indicate some form of infection. In 90 % of these cases, the inflammation is usually relatively mild and is due to one of the following three agents

- Candida albicans
- Gardnerella vaginalis
- Trichomonas vaginalis

The remaining 10 % cases are more serious. They may cause painful sores, tumour-like lesions, spread into the pelvis or cause generalised infection.

Clinician's Role

History

The following points should be included in the history of a woman complaining of white discharge

- Age
- Marital status
- Character of leucorrhoea, its duration, timing with respect to menstruation, vulval irritation or any other associated symptoms like itching
- History of contraceptive use
- Menstrual history, LMP
- Obstetric history
- Past medical history of tuberculosis, anaemia, dysentery, diabetes, psychiatric illness and history of taking antibiotics
- Emotional stress
- Nature of work

Examination

- General Examination: Required to detect ill health, anaemia, colitis or any other systemic illness
- Abdominal Examination: To detect any pelvic tumour or inflammatory lesions
- External Examination of the Vulva: Vulva, perineum and thighs are inspected for signs of excoriation. The vestibular glands and urethral meatus are observed and palpated
- Per Speculum Examination: Vaginal walls and cervix are examined through a speculum. The normal vaginal epithelium is pink, the rugae are well marked and the epithelial surface of the cervix smooth and moist. Normal discharge is like curdled milk and is white and odourless
- Bimanual Examination: Should be done always. In sexually inactive girls the vaginal examination is done under anaesthesia

Investigations

While doing the examination, specimens of discharge are taken for microscopy (wet mount or gram staining), culture and a cervical smear for cytology. Other investigations like blood, urine and stool examination may also be required especially in adolescent girls when the discharge is thin and watery.

- Blood examination for haemoglobin, VDRL and sugar
- Urine examination for urinary tract infection
- Stool examination for ova parasites and cyst

Collection of the sample

Collection of the sample is done with a cotton swab instead of a pipette to collect the secretion. The secretion is gently spread on the glass slide and the slide immersed in equal parts of 95 % alcohol and ether and kept for 15 minutes for the fixation of the smear. The slide can then be sent for gram staining.

In case of wet mount microscopy the vaginal secretion is mixed with saline on the warm slide and a cover slip is placed on it. The wet film is examined under the high power of the microscope immediately.

Cervical scraping is done by revolving Ayre's spatula for 360 degrees over the portio vaginalis after it has been exposed by the Cusco's speculum. Non absorbent cotton swabs can be used instead of Ayre's spatula. This is a method of choice for detection of cervical lesion.

As the health posts and dispensaries do not have investigation facilities, the patient has to be referred to the upgraded dispensary for investigations (wet mount microscopy and gram staining).

Treatment

If the cause is physiological, then all that the patient requires is reassurance. If the cause is pathological, then the treatment should be given accordingly. It is very essential to remember that both partners need to be treated if the disease is sexually transmitted. Emphasis should therefore be made regarding completing the full course of treatment. One should keep in mind that the patient may not always follow the advice given to her/him for various reasons. The clinician should try to identify the reasons for not complying with the advice and try and address them.

Information and Counselling

Before the patient leaves the OPD, the clinician should try and give as much information as possible to her/him. Ensure that the patient has been told about the diagnosis, the investigations required, how to take the treatment and for how long. Make sure that the patient has understood the instructions and emphasise partner treatment whenever required. The patient should be totally made aware of the implications of the investigations and treatment in terms of time, cost, and outcome. The problems of the patient in complying with the clinician's advice should be identified and correct information should be given to the patient in a convincing manner. When telling women about personal hygiene, it should be explained that they should not scratch the vulva with their nails. The woman should also be told to keep the genital area dry to prevent the growth of fungus.

Follow up

The patient is asked to come for a follow up after 7 days. During the follow up visits

- Inquire whether the symptoms are improving.
- Inquire whether the patient was able to follow the treatment given.
- Inquire whether the patient has any complaints after taking the drugs.

Referral

The patient should be referred to the Post Partum Centre/Maternity Home if her health status deteriorates.

Candidiasis

Introduction

Candidiasis, also called Moniliasis, is caused by the organism called Candida albicans. This organism may exist as a normal commensal in the rectum and small numbers may also be found in the vagina, the acid medium suiting their survival without causing any symptoms. The patient's fingernails may harbour the yeast. Sexual transmission is also possible. Symptomatic infection is most likely to arise when there are predisposing conditions. For example:

Pregnancy: During pregnancy the vagina provides a tropical micro climate. The high concentration of sex steroids in the blood maintain an increased glycogen formation in the vaginal epithelium and may alter the local pH, making the environment conducive to the growth of the organism.

Immunosuppressive Therapy: Like treatment with corticosteroids or cytotoic drugs.

Glycosuria: This may be due to undiscovered diabetes, but again a mild degree of glycosuria may exist in a normal pregnancy due to lowering of the renal threshold for sugar.

Antibiotic Therapy: Systemic antibiotics destroy the normal bacteria thus reducing the competition for nutrients leaving the field clear for C albicans.

Chronic Anaemia: Normal iron stores are needed to maintain an adequate immune reaction. This also entails adequate folic acid intake. The angular stomatitis of chronic anaemia is due to Candida infection.

Symptoms

The patient is usually between 20 and 40 years of age when oestrogen support of the epithelial glycogen content is at its highest. The complaint is of profuse thick curdy white irritant discharge and dyspareunia. Itching, chaffing or soreness of the inner side of the thigh and burning sensation of the vulva may also be reported by women.

Examination

Examination reveals an inflamed and tender vagina and vulva with white plaques resembling curdled milk adhering to the vaginal wall and vulva. Removal of the plaque reveals a red inflamed area. Curdy, white or thin watery vaginal, pre pubertal or post menopausal infection is uncommon. But if it does occur after menopause the symptoms tend to be severe.

Investigation

The investigation required is a microbiological examination of the vaginal discharge. On wet mount microscopy, Candida albicans looks like a long thread like fibre with bamboo shoot like buds.

Management

Clotrimazole/Miconazole vaginal pessaries (200 mg) to be inserted into the vagina at bed time for 3 days or Nystatin vaginal pessaries (1,00,000 U) for 14 days.

Orally tablet Sysconasole 150 mg/1 day or tablet Ketoconazole 2 tablets/ 5 days should be given.

Patients who have been prescribed ketoconazole may rarely develop adverse reactions like pruritis, headache, vomiting, ataxia, gynaecomastia, reversible hepatotoxicity.

The partner requires treatment if symptomatic.

If the woman is expressing vulval itching or tenderness, it is recommended that she wash her genitals with clean water and soap and then apply either Betadine, Miconazole or a Cortiosone cream to the inflamed area. She should be informed that the discomfort will reduce after the treatment begins.

Sexual intercourse should be avoided during treatment as it will cause further irritation.

Follow up

The patient should be asked to come for a follow up visit after 7 days. During the follow up visit

- Inquire whether the symptoms are improving.
- Inquire whether the patient was able to follow the treatment given.
- Inquire whether the patient has any complaints after taking the drugs.

Prevention

Some women are prone to recurrent infection with Candida albicans because of contraceptive use, which contain progesterone such as oral pills, injections or implants. Or they may be on antibiotics or cortisones. HIV and diabetes could also be the underlying cause of the recurrent infections. The woman needs to be investigated further in case of recurrent infection.

Women who are prone to yeast infection can help prevent it by

- Increasing the lacto bacillus in the vagina by eating yogurt.
- Avoiding underclothes made of synthetic material.

Trichomoniasis

Introduction

Trichomoniasis is one of the most common causes of vaginal infection. Trichomonads can survive outside the vagina on washed clothes for about 6 hours.

Symptoms

Trichomoniasis is caused by the motile Protozoon, Trichomonas vaginalis. It is an extremely common cause of leucorrhoea and frequently is asymptomatic. It causes an acute vagnitis with a frothy greenish yellow or clear, sometimes watery, discharge. Occasionally, the discharge may be mucopurulent. Usually it is profuse and produces an irritating vulvitis that results in marked pruritis, chafing and dyspareunia. Even digital examination or the passage of a speculum may be painful, and there may be a generalised complaint of headache, backache or pelvic pressure. A characteristic fetid odour may be the only complaint.

Examination

Examination reveals a reddening of the labia minora, occasionally with intertrigo of the inner thighs, a typical discharge oozing from the introitus and a vaginal membrane which may be fiery red. The vagina may be covered with multiple round, red papules giving a strawberry like appearance to the epithelium. The cervix may be red and may bleed easily when touched.

Investigation

- Examination of the vaginal discharge by a saline wet mount: the parasites are recognised by their characteristic rotatory movement. Plenty of pus cells, organisms and epithelial cells are also seen in the preparation.
- Giemsa stains and cultures are useful in accessing cure and in detecting extravaginal sources of infection.

Management

Temporary relief from the symptoms is usually accomplished easily but a permanent cure is difficult and at times seems almost impossible.

An oral preparation of Metronidazole 400 mg b.d. is given for 5 to 7 days. If given to both husband and wife, it gives excellent results. Also Imedile vaginal tablets should be prescribed for 6 days.

Bacterial Vaginosis

Introduction

Bacterial Vaginosis is also called Gardenerella vaginalis, Haemephilis Vagnitis or non specific vaginitis.

Symptoms

The patient complains of persistent foul smelling (fishy odour) thin, watery and greyish discharge. Some patients may complain of pruitis, pregnancy of mictuirition, dysuria and dyspareunia. Bacterial vaginosis is caused by the organism Gardenerella vaginalis which is a gram examination negative coccobacillus (facultative anaerobe).

Examination

Perspeculum examination reveals a thin greyish discharge with a fishy odour.

Investigation

- On wet mount microscopy, the smear shows a presence of clue cells. Clue cells are vaginal epithelial cells with attached gram negative organism.
- Diagnosis with gram stain can also be done.

Management

- Oral Metronidazole 400 mg b.d. for 7 days. Or Doxycycline 100 mg b.d.f or 5 to 7 days
- Male partners should also be treated.
- Pregnant and breast feeding women should take Ampicillin 250 mg, 4 times a day for 7 days.
- For a male Metronidazole should be prescribed even if there are no symptoms. When a repeat course of the drugs is required it is recommended that 4 to 6 weeks elapse between the two courses.
- Instruction in personal hygiene should be given.
- About a quarter of all patients who are relieved of symptoms by initial therapy have no recurrence.
- Clotrimazole vaginal pessaries (100 mg) for 7 days. (Indicated only in case of mixed infections).
- For vulval itching apply Canesten or Imedile, Surfaz or Candid cream.
- Pregnant women should not take Metronidazole in the first trimester. Doxycycline is not to be given in pregnancy.
- Lactating women should be treated by a single dose. However, if there is difficulty in tolerating the single dose, divided doses of 400 mg b.d. Metronidazole may be given for 5 days

Patients taking Metronidazole may develop adverse reactions like nausea, vomiting, anorexia, abdominal pain and a metallic taste in the mouth.

Inform the patient that neither she nor her partner should consume alcohol during treatment. Taking the drug and consuming alcohol can cause stomach cramps, nausea and vomiting.

Vaginal Discharge in Adolescent Girls

Adolescent girls commonly come up with complaints of white discharge. The discharge may either be a thin, watery discharge with a fishy odour characteristic of bacterial vaginosis or thick curd like discharge characteristic of candidiasis.

Girls with complaints of excessive thin watery discharge may have underlying urinary tract infections, parasitic infections or may be anaemic. It is therefore necessary to get haemoglobin levels, urine and stool examinations done. If the investigation reports are positive the treatment is started accordingly. If the reports are normal the girl and her mother should be reassured, given dietary advice and asked to maintain personal hygiene.

Women's Perceptions

Women will complain if

- There appears to be an excessive amount of staining on the clothes.
- They detect an offensive smell.
- They suffer irritation.

There is often little correlation between symptoms and signs. Some fastidious women will complain of what is really normal. On the other hand, gynaecologists regularly observe heavy and purulent discharge in women who deny any symptoms at all.

Terminologies commonly used by women to describe their symptoms

Women commonly refer to white discharge as *safed pani*. The description, however, varies from woman to woman

"It is like the white portion of the egg."

"It is like buttermilk."

Women also expressed feeling weak after the white discharge

"It is watery and sticky. It comes before the period. There is pain in the abdomen just as if I was going to get the period."

Women's expressions of normal and abnormal discharge

Most women make a distinction between heavy and abnormal discharge. Heavy discharge is related to when and how long it occurs and the amount of liquid flow.

Many women are worried about the white discharge because along with the discharge there is also severe itching, irritation on the vulva or severe weakness.

Some women are embarrassed about telling the doctor about their discharge or to convince the doctor that what they were experiencing was not normal.

Women attribute various causes for white discharge.

Gender Issues in RTIs

- Women are usually too shy to talk about white discharge.
- Woman found with RTI may be labelled a 'loose woman'.
- Decision makers of the family like mother-in-law take the woman to the health care facility for problems in pregnancy or infertility rather than for 'trivial' symptoms like excessive vaginal discharge ·
- Women are taught to silently suffer problems related to their reproductive organs.
- Reluctance to seek health services may also be due to inadequate sex education and less access to medical care.
- White discharge is generally regarded by women as 'normal' and a fact of their existence as women. It is considered stigmatising when it interferes with their prescribed functions and they have to take treatment.

(Source: ***Where Women Have No Doctor, A Resource Guide for Women's Health,*** *VHAI., New Delhi, 2001.)*

References

Kistner R. W. (1986), **Gynaecology Principles and Practice,** (4th edition). Published by Year Book Medical Publisher

Dawn C. S. (1994), **Text book of Gynaecology and Contraceptives,** (4th edition). Published by Shrimati Arti Dawn, Kolkatta.

Govan A.D.T., D.M. Hart, R. Callander (1992), **Gynaecology Illustrated,** (4th edition). Published by Churchill Livingstone.

BMC, LTMC & LSTM (1996), **PID Research Study** (Unpublished reports of In-depth Interviews).

Women Centered Health Project (2003), **Protocols prepared by Clinical Subcommittee** (Unpublished) BMC, Mumbai.

International Women's Health Coalition (1983), **Training Course in Women's Health Module 9 Women's Health Problems,** Institute for Development Training, Chapel Hill, NC, USA.

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VAGINAL DISHARGE IN SEXUALLY ACTIVE WOMEN OF REPRODUCTIVE AGE-GROUP

General Examination, Speculum Examination
Send sample for laboratory investigations to upgraded dispensaries

thick curdy white discharge with pruritis and yeast cells on wet mount

Treat for Candidiasis
Local:
Clotrimazole/Miconazole vaginal pessaries (200 mg) to be inserted into the vagina at bed time for 5-7 days or
Nystatin vaginal pessaries (1,00,000 U)
for 14 days
Oral : Tab. Sysconazole 150 mg/ 1 day or Tab. Ketoconazole 2 tablets /5 days

Treat male partners

Health Education

foul smelling greenish yellow discharge with pruritis and Trichomonas seen on wet mount

Treat for Trichomoniasis
Oral: Tab. Metronidazole 400 mg b.d. for 7 days.

Local: Clotrimazole vaginal pessaries (100 mg) for 7 days. Or Imedile vaginal tablet for 6 days.
[Indicated only in case of mixed infections]
For vulval itching, apply imedile, canesten, surfaz or candid cream.

Treat male partners

Health education

foul smelling (fishy) thin watery discharge and clue cells seen on wet mount

Treat for Bacterial Vaginosis
Tab. Metronidazole 400 mg b.d. for 7 days. Non-pregnant women can be given Doxycycline 100 mg b.d. for 7 days. Health Education
Treat male partner

mucopus seen in cervix and gram staining

Gonococci seen on gram staining

Tab. Doxycycline 100 mg/bd/7 days or
Tab. Tetracycline 500mg/q.d.s./7 days
Tab. Erythromicin 500 mg/qd.s./7 days
Examine and treat partners

Health Education and Counselling

Gonococci not seen. Groups of leucocytes seen.

no discharge seen on speculum examination

No treatment is required

Follow Up after 7 days

clinical cure

discharge

assess treatment compliance

good

Refer to peripheral hospitals

bad

start protocol again

N.B. Patients with repeated cervical infection and chronic cervicitis should have Pap Smear.

REPRODUCTIVE TRACT INFECTIONS

Contents

- Introduction
- Definitions
- Prevalence of RTIs
- Consequences of RTIs
- Interventions in RTIs
- Framework for RTI interventions
- The Identification and Treatment of Established Infections
- Minimising the Complications of Infection
- Major Challenges

Introduction

Reproductive Tract Infection (RTI) is an infection in the genital tract or the pelvic area. According to World Health Organisation estimates about 250 million people become infected with sexually transmitted infections each year. Both men and women can get infected with RTIs. However, it is women who suffer more because they become social outcasts. Besides causing suffering and pain, RTIs can also lead to infertility, ectopic pregnancy and death.

More than 5,00,000 women die every year due to pregnancy and childbirth related causes. These women could be saved if RTIs were treated and safe medical procedures were adopted. Syphilis in women not only causes infertility and death, it is also responsible for abortions, stillbirths, neonatal deaths and infected infants.

RTIs are preventable and they can be treated. Health care providers need to be aware that they have a major role to play in educating and counselling women with RTIs. They also need to share information about prevention and treatment of these diseases.

Definitions

There are three categories of RTIs

1 Endogenous Infections

These infections are caused by an overgrowth of the normal flora due to ecological disturbances. The commonest endogenous infections are

- Candidiasis
- Bacterial vaginosis (most common)

2. Sexually Transmitted Infections (STIs)

STIs are a sub-group not always more prevalent but often confused with the whole category. The commonly seen STIs are

- Gonorrhoea
- Chlamydia
- Trichomoniasis (most common)

3. Iatrogenic Infections

These are infections are associated with medical procedures, particularly in transcervical procedures like IUD insertion, abortions, and menstrual regulation.

It is important to know the different kinds of RTIs because they have different implications in terms of understanding causalities and for defining the most appropriate intervention strategies. Thus for prevention of

Endogenous Infections

- Change of behaviour.
- Minimising the overuse of drugs.
- Maintenance of personal hygiene.

Sexually Transmitted Infections

- Safe sexual behaviour should be practised.
- There should be stress on barrier contraception and personal hygiene.

Iatrogenic Infections

- Quality of procedures should be maintained.
- Procedures should be done with absolute aseptic precautions.

Prevalence of RTIs

RTIs are a common cause of gynaecological morbidity. The prevalence rates are extremely variable (often within the same city also). There is a need to focus on RTIs as there are no readily discernible patterns to indicate which women are most in need of medical attention and care.

Problems Highlighted by Prevalence Studies

- Many infections are asymptomatic, particularly in women. This is particularly true of cervical infection with gonorrhoea and chlamydia. This is a problem that obviously arises when the solution offered to diagnose infection is to do syndromic management, which requires that women have symptoms in order to receive treatment.
- Women's perceptions of RTI symptoms do not map well with bio-medically defined clinical syndromes.
- There is tremendous variability in clinical and laboratory diagnostic criteria. This variability is in terms of the quality of laboratory tests conducted and the difference in training received by the health providers.
- There is little consensus regarding normal and abnormal conditions. Some conditions considered normal in one country's medical culture may be considered abnormal in other countries.
- Prevalence is likely to change over time.

Further, there is a very poor correlation between reported symptoms, clinical diagnosis and the presence of laboratory-confirmed infections.

Consequences of RTIs

- A number of pregnancy related complications have been associated with one or more RTIs
  - Foetal wastage (Bacterial vaginosis)
  - Low birth weight (IUGR- Intrauterine growth retardation)
  - Congenital infection (syphilis, gonorrhoea and chlamydia)
  - Premature delivery
  - Premature rupture of membranes
- The susceptibility to HIV infection is increased in patients suffering from certain RTIs
- A significant portion of lower RTIs caused by sexual transmission progress to the upper reproductive tract and are called Pelvic InflamImatory Disease. This has been associated with increase in rate of
  - Childlessness
  - Ectopic pregnancy
  - Development of chronic pelvic pain
  - Menstrual disorders
  - Dyspareunia

Interventions for RTIs

Any intervention programme should have a dual goal

1. Reduce symptoms and consequences of RTIs in women
2. Reduce transmission of STIs within the community

Hence, multiple strategies need to be adopted in the intervention programme. These should focus on

- Behavioural change.
- Clinical - improving the quality of care.
- Making the services more accessible.

Framework for the Content of RTI Interventions

- Primary prevention of infections
- Identification and treatment of established cases
- Minimising complications
- Major challenges

Primary Prevention of Infections

- Prevention of Endogenous Infections
- Prevention of STDs
- Prevention of Iatrogenic Infections

Primary Prevention of Endogenous Infections

- Changes in menstrual management practices (importance of maintaining menstrual hygiene)
- Use of harmful intravaginal products like tampons and herbal products should be reduced
- Improve reproductive awareness and appropriate health seeking behaviour
- Appropriate antibiotic use
- Maintain proper health, timely diagnosis and treatment of complicating factors like diabetes and Urinary Tract Infections (UTIs)

Primary Prevention of STIs

- Delay coital debut.
- In adolescents the genital tract is immature, therefore they are more susceptible to infections especially with chlamydia and HIV.
- Partner reduction and selection.
- Condom promotion.
- Female controlled barrier contraceptive methods like the diaphragm and female condom.
- Reduce non-consensual sex.

Primary Prevention of Iatrogenic Infections

- Improve infection control practices in service delivery settings.
- Improve overall quality of care, especially the technical competence of providers.
- Whether prophylactic use of antibiotics during procedures like menstrual regulation and insertion of copper T, will reduce infection is not certain.
- Reduce unsafe abortions by increasing access to safe abortion service centres.
- Expanding contraceptive choice thereby decreasing the demand for abortions.

The Identification and Treatment of Established Infections

Management of symptomatic infections

- Aetiological diagnosis
- Syndromic management
- Role of risk screening
- Screening for asymptomatic infection case finding, eg antenatal screening for syphilis (cost effective)
- Partner treatment: Treating the partners of men who have symptoms of genital infections
- Mass treatment approaches eg neonatal ophthalmia prophylaxis (very cost effective procedure for gonococcal infections)

Minimising the Complications of Infection

- Improvement in management of abortions in order to prevent septic abortions.
- Improvement in management of ectopic pregnancies.
- Management of infertility (often ignored because it is expensive).
- Cervical cancer screening program.

Major Challenges

There is a need to define and evaluate affordable service packages for prevention and treatment of RTIs in diverse programme settings by

- Linking existing services and improving their quality.
- Reaching new population eg youth.

There is also a need to improve the technology for

- Diagnosis of the disease.
- Prevention of the disease.
- Safe medical abortion practices.
- Standardisation of the definition of each infection, so that it becomes easy to diagnose and treat.

References

Reproductive Tract Infections by Dr. Christopher Elias, a Seminar for Clinicians of Brihanmumbai Municipal Corporation, March 30, 1998.

Health Action Information Network (1998) **Proceedings of the 2nd Regional Consultation on Reproductive Tract Infections in Asia and the Pacific**, Philippines

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Handout 9

SEXUALLY TRANSMITTED INFECTIONS

Contents

- Introduction
- Magnitude of the STI problem in India
- Social Aspects contributing to STIs
- Types of STIs

Introduction

Sexually Transmitted Infections (STIs) are a group of communicable diseases, transmitted predominantly by sexual contact. Traditionally, this group of diseases included gonorrhoea, syphilis, chancroid, lymphogranuloma venereum (LGV), donovanosis (Granuloma Inguinale) herpes progenitalis and condyloma accuminata. However, over the years, a number of other diseases have been recognised and the list has expanded to include genital scabies, pediculosis, pubis and genital molluscum contagiosum, urethritis and vaginitis.

The Hepatitis B infection has gained importance due to its possible morbidity and mortality and is also considered a part of STDs. HIV infection and AIDS are the latest addition to this list.

STIs are one of the most common causes of morbidity and in many developing countries this group of diseases ranks among the top five diseases for which health care services are sought. The World Health Organisation (WHO) estimates that globally each year there are at least 250 million new cases of STIs.

Magnitude of STIs in India

Although there is no comprehensive data on the incidence of STI in the country, it is possible to estimate the size of the STI problem. This estimate is based on a review of STI studies carried out on a number of STI baseline surveys, recently conducted in Chennai and rural areas of Tamil Nadu, Jaipur and Kolkata.

The prevalence of STI in various population groups ranges from 1.7 % to more than 10 %. Even in rural areas, the prevalence of positive syphilis serology (VDRL positive) was found to be 4.2 % for females and 4.4 % for males. The rates of infection in groups with high-risk behaviour can be as high as 75 %.

The total annual incidence of all STIs in India is estimated at 5 %. Thus, it is estimated that each year approximately 40 million new STIs occur.

Factors Contributing to the Magnitude of the Problem

- Many STIs are asymptomatic and these patients usually do not seek medical attention. Hence, they may unknowingly spread the infection with serious complications such as infertility, chronic abdominal pain, PID and ectopic pregnancy.
- Awareness about the signs and symptoms of STIs are poor. There is usually little knowledge about the symptoms of STI, especially among women. Thus, even in the presence of symptoms such as vaginal discharge, many women do not seek medical attention.
- Among both men and women there is in general a lack of awareness about the seriousness of STIs and the need for adequate and effective treatment. Thus, many people with STIs delay seeking medical treatment or seek treatment from non-qualified sources. Many people do not complete the treatment course, risking chronic infections
- The social stigma attached to STIs prevents patients from approaching health facilities.
- Failure to treat patients effectively: Patients with STIs can only be cured if appropriate antibiotics are provided and are eaten by the patients. The diagnosis of an STI is often difficult because the same symptom can be caused by different organisms. Further the diagnosis is difficult because many patients come late, after having tried other treatment.
- Failure to treat partners: Even if a person with an STI seeks treatment, there is often no attempt to treat the partner(s) of the patient. This in turn leads to a further spread of the infection, and also a possibility of re-infection of the patient. The patient's collaboration in referring his or her contact(s) for clinical management should always be sought.
- Failure to promote preventive measures: Prevention is the only answer to avoid STIs. Taking preventive measures is also essential to prevent infections with bacterial STIs. Preventive measures include a reduction in the number of sexual partners, ideally to one, single and uninfected partner, or the consistent use of condoms. STI patients should always be educated and counselled on both prevention and on the use of condoms.

The stigma attached to sexually transmitted diseases makes it difficult to address these constraints. Yet, with education it is possible to increase awareness about STIs, to improve health care seeking behaviour and to promote safer sexual behaviour.

A number of social factors also contribute to the spread of STIs

- Urbanisation and industrialisation
- Migration
- Social disruption
- Work related migration and travel
- Socio-economic problems and lack of economic opportunities
- Changing societal values
- Alcoholism and other drug abuses

Social Aspects Contributing to STIs

STIs have been in existence for centuries. The risk factor for contracting an STI is having many sexual partners, or having a partner who in turn has many sexual partners. Although anyone can get an STI, certain groups of individuals are more prone due to their lifestyle and social or economic circumstances. These include

- Migrant workers who live away from their f amilies
- Men who travel as part of their work
- Those who resort to selling sex for financial reasons
- Armed forces personnel who are posted away from their families
- Young adults due to curiosity and peer pressure

The conditions under which many people live also exposes them to behaviour options which place them at an increased risk of contracting STIs.

Abstinence or a mutually faithful relationship with one partner are effective ways of preventing STI. However, those who habitually have more than one partner will not change their behaviour easily so they can be convinced to use condoms and seek proper treatment for STIs. In this age of AIDS, practical messages and approaches are also essential.

For the treatment to be successful it is important that the whole course of treatment is taken, even if a patient feels better after a few days. Incomplete treatment might lead to chronic infection, with potential serious long-term consequences. It will also lead to emergence of resistant strains.

Since an infected patient infects other partners or may even re-infect himself/herself it is essential that partner(s) of STI patients be medically examined and treated if found infected.

Advice should be given to prevent future infections with STI, including the HIV infection. This includes recommending reducing the number of sexual partners and the consistent use of condoms. Where possible one or more good quality condom should be given to the patient. Clear and simple instructions on condom use should be provided; a condom demonstration may also be required

The patient should be advised to return if the symptoms do not disappear and to seek adequate health care for any future episodes of STI.

Basic information that most STIs are curable, with the exception of HIV and other viral infections, should be provided. The long-term health consequences of chronic STI should be emphasised.

It will often not be possible for the treating physician to spend adequate time with each patient for health education and counselling. Hence health education and counselling can also be done by sympathetic male or female multipurpose workers or by nurses. However, since the treating physician commands respect from the community and the individual, his/her message has a greater impact and so attempts should be made by the treating physician to spend as much time as possible with the patient.

One of the most important aspects of the management of patients with STIs, and of health education and counselling for infected patients, is a sympathetic and non-judgmental attitude. Moralistic messages and condemning attitude of health care workers are counterproductive. These will only help in driving the patients away.

What are essential are privacy, confidentiality, and an atmosphere of professionalism, where STIs are treated as any other disease. This will in turn contribute to controlling STIs, including HIV and AIDS.

Types of STIs

Gonorrhoea

Introduction

Mucopurulent Cervicitis is an inflammation of the cervix accompanied by a discharge of mucus and pus. The two most common organisms responsible for this discharge are Neisseria gonorrhea and Clamydia trachomatis.

Symptoms

- Persistent vaginal discharge, which is white or yellowish.
- Spotting or bleeding between menstrual periods or pain during or after intercourse.

However, more often than not women may not have any symptoms since about 90 % of the women do not show the symptoms for gonorrhoea. A woman may also have fever, abdominal pain, backache, dysuria, painful or excessive menstrual periods which are commonly seen between menarche and menopause

Per-Vaginal Examination

- Cervix appears swollen, reddened or eroded with a foul smelling discharge.
- Swelling of glands around the vaginal entrance, sometimes quite large.
- The rectum may be inflamed and have a discharge.
- Cervix, uterus, and the fallopian tubes may be tender and swollen.

Investigations

Discharge may be seen under microscope using Gram's stain.

Please Note

- Untreated gonorrhoea can lead to
  - Chronic pelvic pain
  - PID
  - Infertility
  - Ectopic pregnancy
  - Urethritis with stricture formation
  - Pain in joints and tendons of wrists and finger
- Infants of infected mothers can develop ophthalmia neonaturum, which can lead to blindness and disfigurement.
- Gonorrhoeal infection may lead to a premature delivery.

Treatment

Irrespective of the Gram staining report gonorrhoea and chlamydia should be treated together. The drugs effective against both gonorrhoea and chlamydia are

Erythromicin 500 mg /q.d.s./ 7 days orally or

Doxycyclline 100 mg / b.d.s./ 7 days orally or

Tetracycline 500 mg /q.d.s. / 7 days orally

The drug of choice is Norfloxacillin 800 mg single dose or Ciprofloxacillin 500 mg single dose or injection procaine penicillin single dose after the test dose. However single dose may lead to recurrent infections.

Only erythromycin should be used during a pregnancy.

Both partners should be treated.

Prevention

Use Silver Nitrate 1 % eye drops, within one hour of birth of a child of an infected mother. Alternately, tetracycline eye ointment 1 % may be used.

Follow up

If there is no improvement after 7 days refer to the Post Partum Centre/Maternity Home/Peripheral Hospital or Teaching Hospital.

Lymphogranuloma Venereum (Buboes)

Introduction

Lymphogranuloma Venereum (LGV) is most prevalent in tropical Asia and Africa. It is caused by Chlamydia trachomatis but by a different type than that which causes cervicitis. If untreated lymphogranuloma venereum can lead to chronic swelling in the vulva and rectal area leading to rectal strictures and recto-vaginal fistulae (an opening between the rectum and vagina). Eventually liver, kidney problems and blood clotting disorders can occur. These can all lead to death.

The presence of a genital ulcer also places women at increased risk of becoming infected with the virus that causes AIDS.

Symptoms and Diagnosis

The incubation period for lymphogranuloma venereum is between 5 and 28 days. The first symptom is a small painless blister or ulcer on the cervix, vagina, or rectum (or the male penis). This heals in a few days and may go unnoticed. Then large dark lumps develop in the glandular areas of the groin accompanied by soreness or stiffness in the groin area. These open to drain pus and scar which opens again. There may also be fever, headache, and vomiting.

Laboratory test

The laboratory test for LGV is not widely available. So a definitive diagnosis is made by a complement fixation process for which a sample of the discharge is needed to conduct the test.

Treatment

Both partners should be treated with Co-trimoxazole [80 mg trimethoprim & 400 mg sulfamethoxazole] 2 b.d.for 10 days or Doxycycline 100 mg / b.d. for 5 days, or Erythromicin 500 mg /q.d.s for 10 days.

Pregnant Women

Tetracycline should not be used for treating pregnant women because it can cause problems with teeth and bone development, especially during the first trimester. Erythromicin is recommended for pregnant and lactating women.

Follow up

The patient should be instructed to return to the clinic if there is no improvement within five to seven days. In such a case, the patient should be referred to an STD specialist for treatment of recurrent or persistent symptoms.

Syphilis

Introduction

Syphilis is caused by the *Treponema pallidum* bacteria and the infection is almost always spread by sexual contact. Whether the probing organ is the penis, tongue (or occasionally the finger) and whether the receiving organ is the mouth, genitals, or rectum, a syphilitic site on either one can infect the other.

Syphilis can also be inherited from an infected mother, resulting sometimes in stillbirth or deformity, and in other cases in a hidden infection which causes trouble at a later date. Two-thirds of pregnancies in women with syphilis have poor outcomes -- stillbirths, neonatal deaths and infant infection.

Symptoms

Syphilis has an incubation period of 1 to 13 weeks (usually 3 to 4 weeks), followed by four stages. Each stage has typical signs and symptoms. These can, however, vary or be absent.

Primary Stage

The first sign appears in the part of the body that has been in contact with an infected person: genitals, rectum, or mouth. A spot appears and grows into a painless sore that oozes a colourless fluid (but no blood). This lesion is known as a chancre. The chancre feels like a button: round or oval, firm, less than 1.3 cm across, and indurated (indented). A week or so later, the glands in the groin may swell. Since they do not usually become tender the swelling may not be noticed. There is no feeling of illness, and the sore heals in a few weeks without treatment. In women, the chancre may not be visible if it is on the cervix or the vaginal wall. This stage may last four to eight weeks.

Secondary Stage

This stage occurs when the bacteria have spread through the body. It can follow the primary stage immediately, but usually there is a gap of several weeks.

- The person feels generally unwell. There may be headaches, loss of appetite, general aches and pains, sickness, and perhaps fever.
- There are breaks in the skin and sometimes there is also a dark red rash which lasts for weeks or even months. The rash appears on the back of the legs and the front of the arms, and often also on the body, face, palms, and soles. The rash may be flat or raised. It does not itch, is not infectious and looks like many other skin complaints.
- Other symptoms include
    - Hair falling out in patches.
    - Sores in the mouth, nose, throat, genitals, or in the soft folds of skin. Like the primary stage sore, these too are highly infectious.
    - Swollen glands throughout the body.

All these symptoms eventually disappear without treatment, anywhere between three weeks to nine months.

Latent Stage

This stage may last from a few months to the rest of a person's life. Even in this stage there are no symptoms. After about two years, the person ceases to be infectious (although a woman can still sometimes give the disease to a baby she bears). But the presence of syphilis can be shown by blood tests.

Tertiary Stage

This stage occurs in about one-quarter of those who have not been treated earlier. The disease now shows itself in a variety of forms and often causes permanent damage in one part of the body.

The most common are ulcers in the skin and lesions on ligaments, joints or on bones. Tertiary syphilis is more serious if it attacks the heart, blood vessels or the nervous system. It can then kill, blind, paralyse, cripple or cause mental disturbances.

Diagnosis

Syphilis is not easy to diagnose since its symptoms are often mild or indistinct. However, the syphilitic chancre is distinct and if it is present and laboratory diagnosis is not available, the treatment protocol for genital ulcers should be followed (given at the end of this module).

Laboratory test

There are a number of blood tests (Serologic Test for Syphilis - STS) and microscopic examinations which can detect the spirochete and antibodies to the spirochete. The health care provider should be familiar with the locally available tests.

Primary and secondary syphilis can be definitively diagnosed by

- Dark-field microscopic examination of fluid from the chancre.
- Fluorescent antibody techniques examining material from the sore or lymph node.
- VDRL (Serological test)

Treatment

Inj. Benzathine Penicillin 2.4 mega units/I.M./ATD/ single dose or

Aqueous Procaine Penicillin 1.2 mega units/IM/ATD/10 days or

Doxycycline 100 mg/b.d./15 days or

Tetracycline 500 mg/q.d.s./15 days or

Erythromycin 500 mg/q.d.s./15 days

Pregnant Women

All pregnant women should be screened during the first trimester, and infected women and their partners should be treated. If needed, screening and re-treatment should be done in the third trimester.

Penicillin is recommended as tetracycline and doxycycline are contraindicated in pregnancy.

Erythromycin is not recommended because it might not cure the foetus.

Infants

Infants should be treated at birth if their mothers were not treated or treated inadequately or if the treatment was administered after 36 weeks of gestation. Hospitalisation and treatment with IV penicillin is recommended.

Treatment for infants when hospitalisation is not available is Procaine Penicillin: 50,000 units/kg intramuscularly once daily for 10 to 14 days.

The eyes of the infants should be examined.

Follow up

If diagnostic facilities are available patients should be re-tested after treatment. If a patient continues to have symptoms she should be re-treated with one of the alternate drugs mentioned above. However, if the symptoms continue past a second treatment another STI including HIV should be suspected and the client should be referred for diagnosis.

Genital Herpes

Introduction

The Herpes Simplex Virus 2 (HSV2) usually causes genital herpes. The genital herpes virus belongs to the same family of viruses that cause what is known as "fever blisters" or "cold sores". These are usually caused by Herpes Simplex Virus 1 (HSV1). However, when sores are present HSV2 can be transmitted to the mouth, face and vice versa during oral-genital contact.

The first lesion usually appears four to seven days after intercourse with an infected partner. However, people can become infected with the virus and not develop the characteristic blister.

The herpes blisters frequently become a recurring condition. The virus can be transmitted through sexual contact whenever there are lesions; it may also be transmitted when no blisters are present. The initial episode of blisters is usually the most uncomfortable and the subsequent episodes are usually not as severe.

There is no permanent cure for herpes. Like other genital ulcers, women who have blisters are more likely to contract HIV. A history of the herpes infection is associated with cervical intraepithelial neoplasia and cervical cancer. Further, infected women also have a higher incidence of miscarriage.

HSV can also be transmitted from mother to child during delivery. Neonatal herpes ranges from being asymptomatic and localised infections to the involvement of the central nervous system which can lead to death.

Symptoms and Diagnosis

- Itching, soreness, small fluid-filled sores that have a colourless discharge.
- Blisters can appear on the labia, clitoris, perineum, anus, vagina and cervix (and the man's penis).
- Blisters can burst and ulcerate.
- The first outbreak of blisters is usually the longest; lesions should heal on their own within two to four weeks. The average length of a recurrent episode is four days.

During the first episode and sometimes during recurrent outbreaks a woman can experience flu-like symptoms, swelling of the lymph nodes in the groin and the lesions may cause painful urination and subsequent urinary retention.

Due to the characteristic appearance of the blisters, herpes can usually be diagnosed by clinical observation.

Laboratory test

If a Pap smear is taken of the blistered area the presence of herpes can be detected. Although not widely available there is also a tissue culture test for herpes.

Prevention

Some individuals never have a recurrence, whereas others experience recurrences of herpes regularly. Recurrences seem to be associated with stress, poor diet, and chronic friction on the labia (caused by tight clothing for example).

Treatment

5 % Acyclovir cream and oral Acyclovir 200 mg five times a day for five days.

Follow up

Women with a history of herpes should get a Pap smear done annually.

Granuloma Inguinale

Introduction

Granuloma inguinale is common in tropical areas and is caused by Calymmatobacterium granulomatis. The incubation period is between one and 12 weeks. Granuloma inguinale is generally spread by sexual contact, but it can also be spread by close physical contact with the lesions.

If untreated, the lesions may also become infected with bacteria. Scarring may remain after treatment and there might also be the formation of keloids. Severe cases can cause enlargement and deformity of the genitals. The bacterium can enter the bloodstream causing fever and general malaise and if untreated can lead to death.

Symptoms and Diagnosis

- A red, painless lesion, or several lesions on the vulva, vagina, and/or perineum (or the man's penis, thighs or scrotum), which ulcerate.
- The lesion may bleed on contact and may enlarge slowly.
- Touching the lesion can spread it.
- Diagnosis can be based on clinical symptoms.

Laboratory test

If a microscope is available the donovan body can be seen on a slide of ulcer smear stained with hematoxylin and eosin.

Treatment

Co-trimoxazole [80 mg trimethoprim & 400 mg sulfamethoxazole] 2 b.d./10 days

Erythromycin 500 mg/q.d.s./10 days or

Doxycycline 100 m.g./b.d./10 days

Chancroid

Introduction

Chancroid is caused by a bacillus Haemophilus ducreyi which is a gram negative organism. Its incubation period is between three and 10 days. It does not spread through the blood stream but the lesions may get secondarily infected.

Symptoms

Women usually do not have any symptoms of Chancroid.

A single or progressive ulcers surrounded by a red circle on the external sex organs may occur.

There may be swollen glands in the groin area on one or both the sides.

Laboratory test

If a microscope is available, a specimen of the discharge can be examined under dark field microscopy. The bacteria should appear in chains or clumps.

Treatment

Co-trimoxazole [80 mg trimethoprim & 400 mg sulfamethoxazole] 2 b.d. / 10 days

Erythromycin 500 mg/q.d.s./10 days or

Doxycycline 100 m.g./b.d./5 days

References

International Women's Health Coalition (1983), **Training Course in Women's Health Module 4 Vaginal Infections and Sexually Transmitted Diseases**, Institute for Development Training, Chapel Hill, NC, USA.

Contributiors - Dr. Rachita Dhurat, Dr. Padma Shetty, Dr. Chitra Naik

GENITAL ULCER

history of ulcers on genital tract

grouped vessicles on vulva followed by tiny shallow painful ulcers that heal spontaneously within 7-10 days without scarring

send sample for laboratory investigation (Tzanck smear - multinucleated giant cells are seen)

Treat for Herpes Genitalis
5% Acyclovir cream and
Tab. Acyclovir 200 mg five times a day for 5 days.
Examine and treat Partners
Health Education and Counselling

single painless clean punched margins, indurated base associated with painless shotty regional lymphnodes

send sample for laboratory investigation
-VDRL / RPR - dark ground illumination -sample for further laboratory diagnosis

Treat for Syphilis
Inj. Benzathine Penicillin 2.4 mega units/I.M./ATD/ single dose or
Aqueous Procaine Penicillin 1.2 mega units/IM/ATD/10 days or
Doxycyclline 100 mg/b.d./5 days or
Tetracycline 500 mg/q.d.s./15 days or
Erythromycin 500 mg/q.d.s./15 days

Examine and treat Partners

Health Education and Counselling

multiple, non indurated painful, discharging ulcers with tender inguinal lymph nodes

send sample for laboratory investigation
-Gram stain
-sample for further studies

Treat for Chancroid
Septran 2 b.d./10 days or
Erythromycin 500 mg/q.d.s./10 days or
Doxycycline 100 m.g./b.d./5 days

Examine and treat Partners

Health Education and Counselling

small non indurated transient asymptomatic ulcer. lymph nodes matted above and below inguinal groove

send sample for laboratory investigation

Treat for Lympho Granuloma Venereum
Septran 2 b.d./10 days or
Erythromycin 500 mg/q.d.s./10 days or
Doxycycline 100 m.g./b.d./5 days

Examine and treat Partners

Health Education and Counselling

raised, bright red, beefy granulomatous ulcer that bleeds on touch

send sample for laboratory investigation

Treat for Granuloma Inguinale
Septran 2 b.d./10 days or
Erythromycin 500 mg/q.d.s./10 days or
Doxycycline 100 m.g./b.d./5 days

Examine and treat Partners

Health Education and Counselling

Follow Up after 7 days

- Improving
  - continue treatment
    - clinical cure
- Not Improving
  - assess treatment compliance
    - good
      - refer to skin department
    - bad
      - start protocol again

Handout 10

CHILDLESSNESS

Contents

- Understanding Childlessness
- Causes of Childlessness
- Investigations for Childlessness
- Management
- Social Implications of Childlessness
- Counselling
- Flow Charts

Understanding Childlessness

Childlessness means the inability to conceive after one year of sexual life without the use of contraceptives. The World Health Organisation, however, defines childlessness as the inability to conceive after two years of sexual life without the use of contraception. Usually 50 % of the women conceive within six months and 80 to 90 % of the couples conceive within one year. In younger couples or those in whom regular sexual exposure is doubted, the investigations and treatment are delayed up to two years.

After discontinuation of the oral contraceptive pill, certain medications (eg Danazol) or the intrauterine device, the first 2 to 3 months may be less than optimal for achieving pregnancy owing to the temporary ovulatory dysfunction or an unfavourable endometrium.

Types of Childlessness

Childlessness is of two types

- Primary childlessness where conception has never occurred.
- Secondary childlessness where conception has failed to occur after a period of fertility.

Effects of Childlessness

In the male dominant Indian society, a woman is generally blamed for the inability to conceive. She becomes a victim of social gossip and harassment from family members, leading to unhappiness, psychosomatic illness and even suicide.

Factors Responsible for Successful Fertility

Both male and female factors are responsible for successful fertility

- Testes must produce healthy motile sperm
- Sperm has to be deposited at the external os which should then be transported through the cervical mucus, uterine cavity and tubal lumen
- The ovary must produce healthy ovum by ovulation
- The ovum should be picked up by the fallopian tube
- Fertilisation occurs at the tubal lumen and the zygote is transported through the tube, to be implanted on the healthy progesterone primed endometrium

Physiological Childlessness

Childlessness is seen in couples who have got married before or after the reproductive age as during these periods ovulation does not occur. Other anovulatory conditions like pregnancy and lactation also lead to an inability to conceive.

Pathological Childlessness

- In 25 % of the cases, the defect lies with the male.
- In 50 % of the cases, female factors are responsible for childlessness.
- In 25 % of the cases, both male and female factors are responsible for childlessness.
- In 10 % of the cases there is no obvious abnormality, which is called unexplained childlessness.

Causes of Childlessness

Male Factors

Systemic Factors

- Age above 45 years
- Obesity
- Fatigue
- Alcoholism / smoking / tobacco/ drugs

Psychological Factors

- Anxiety and apprehension
- Nervousness about ability to perform sexual act appropriately
- Psychiatric illness

Coital difficulties

- Ignorance about sex
- Infrequent coitus
- Severe phimosis and hydrocoele
- Impotence
- Premature ejaculation

Endocrinopathy

- Hypothalamic - pituitary dysfunction
- Hypothyroidism
- Diabetes

Immunologic

- Sperm auto-antibodies are present in cases of vas obstruction, orchitis, or following testicular biopsy

Genital Factors

- Defective spermatogenesis due to undescended testes, hypospadiasis, Klinfelter Syndrome, testicular damage following mumps, varicoceles, huge hydrocele, exposure to extremely high temperatures as in furnace, bhatti, exposure to radiation
- Tight and /or synthetic underpants

Female Factors

Systemic Factors

- Age above 35 years
- Tuberculosis
- Severe malnutrition

Psychological Factors

- Fear of doing sex
- Marital disharmony leads to tubal spasm and infrequent coitus
- History of sexual abuse

Endocrinopathy

- Thyroid disorders
- Hypogonadotrophic disorders Hypothalamus-Pitiutary-Ovarian dysfunction
- Polycystic ovarian diseases

Immunologic

- Antibodies against sperm is present in cervical mucus or in the women's serum

Genital Factors

- Vaginal factors
  - narrow vaginal introitus
  - vaginismus
  - vaginitis
  - vaginal atresia
  - vaginal stenosis

Genital Factors

- Genital duct obstruction and inflammation in hemiorrhaphy, hydrocoele repair, vas ligation, and uretheritis
- Sexually Transmitted Infections
- Diseases of Testes like Tumour, Tuberculosis

Genital Factors

- Cervical factors
  - thick cervical mucus
  - elongation of cervix
  - intracervical obstruction
  - cervical scarring
  - cervicitis with poor mucus and pus cells
  - cervical polyp
  - sperm antibodies in cervical mucus or women's serum may hamper sperm motility
- Uterine factors
  - uterine fibromyoma
  - uterine anomalies
  - uterine hypoplasia
  - tubercular endometritis
- Tubal factor
  - tubal occlusion or peritubal adhesions caused by gonococci, pyogenic, TB, chlamydia, appendicitis
- Ovarian factors

  Endocrinopathy like

  Hyperprolactinaemia Galactorrhoea

  inadequate luteal phase due to hyperprolactinaemia and
  - hypothyroidism
  - chocolate cyst- Endometriosis,
  - ovarian tumour
  - premature ovarian failure
  - lutenised unruptured follicle
- **Peritoneal factors**
  - peritubal adhesion
  - pelvic endometriosis

Most childlessness patients have problems due to

- Inadequate sperm production
- Failure of ovulation
- Abnormalities in female genital tract

Behavioural practices among childless couples

Women

- get up immediately after intercourse (43.44%)
- wash genitals after intercourse (37.56%)
- spillage of semen after intercourse (85.97%)
- raise their lower back after intercourse (28.05%)

Men

- withdraw penis immediately after intercourse (62.90%)
- problems with erection of penis (93.21%)

(Source : Veena B Mulgaonkar ; ***A Research and an Intervention Programme on Women's Reproductive Health in Slums of Mumbai,*** *Sujeevan Trust, Mumbai, undated.)*

With some thought to the various dimensions of the problem and experience, a 3-level approach can be devised

Level - I

What can be diagnosed by any trained health worker by simple questions even at the patient's home.

Level - II

What can be diagnosed by any general physician, with some training, from a good physical examination of the patient at the health centre.

Level - III

What can be diagnosed only by referral to a specialist at a large hospital.

One third of all childless couples conceive during and following basic investigations and current treatment.

Investigations for Childlessness

When to Investigate?

90 % of the couples conceive by 18 months of sexual exposure without contraception.

Investigations are required when

- A woman between 18 and 25 years does not conceive after 2 years of normal sexual life.
- A woman between 25 and 35 years does not conceive after 1 year of normal sexual life.
- A woman above 35 years does not conceive after 6 months of sexual life.

At the Primary Level (Health Post / Dispensary)

Clinical Evaluation of Women

When a woman comes with the inability to conceive, a detailed history of the woman is noted

- Age
- Married for how long
- History of menstruation (details of menstruation cycle)
- Pain during menstruation
- History of an abortion /MTP
- History of contraceptive use
- Sexual history: frequency, pain during coitus, timing of sexual intercourse in relationship to menstrual cycle
- History of previous major surgeries
- Any treatment taken or investigation done for childlessness
- History of previous pregnancy
- History of systemic diseases (tuberculosis, diabetes)
- History of addictions

It has to be explained to the woman about how conception takes place, and the emphasis has to be that both male and female factors are responsible for conception. She should be told that in 25 % of the cases, the cause lies in the male factor. The clinical evaluation and semen analysis of the husband should be done before proceeding with any examination or investigation of the woman.

Clinical Evaluation of the husband

- Clinical Evaluation
  - Age
  - Sexual history (coital frequency)
  - History of smoking
  - History of addiction: alcohol, drug abuse, tobacco
  - History of systemic diseases (tuberculosis/diabetes/mumps)
  - Complete health check up
  - Examination of genital organs
- **Semen analysis**

The husband can be referred to the nearby teaching hospital for semen analysis by clinicians at the health post and dispensary. For this the man has to abstain from sex for three days, following which the semen is ejaculated into a wide mouth glass jar by way of masturbation. The semen sample is examined after half an hour of collection on liquefactions.

Normal semen analysis

- Volume 2 - 5 ml.
- Sperm count 20 million to 200 million per ml.
- Sperm morphology - at least 60 % of sperms should have normal morphology.
- Sperm forward motility - at least 60 % of sperms should be forward motile at the end of an hour or at least 50 % at the end of 2 hours.

The motility is labelled as excellent (Grade II) if the sperms show vigorous rapid forward movement and good (Grade III) if the sperms progress forward with good speed.

If the semen analysis report is normal, no repeat semen testing is required.

Abnormal Semen Analysis

The following abnormalities may be seen

- Aspermia: absence of semen
- Oligospermia: number of sperms is low. This could be due to low volume of semen (2 ml) or a high volume of semen (more than 5 ml)
- Azoospermia: absence of sperms. This condition is seen in 10 % of all infertile males
- Oligozoospermia: sperm count less than 10 million per ml
- Polyzoospermia: sperm count more than 250 million /ml
- Teratozoospermia: more than 40 % of the sperms are abnormal

If the sperms have no motility, the condition is labelled necrozoospermia (Grade 0). If the motility of the sperms is weak or there is a sluggish forward progression of sperms, it is labelled Grade I.

When there are more than 5 pus cells per high power field, it is taken as evidence of infection in the genital tract.

In cases of Azoospermia, the fructose content of semen is analysed. If fructose is absent it indicates seminal duct obstruction.

> When the semen analysis report is abnormal, it is repeated three times at monthly intervals.

Routine Laboratory Tests

The health post and dispensary doctors have to ask for the following investigations to be done along with the semen analysis

- Haemoglobin
- Blood group: ABO Rh typing
- VDRL
- Post prandial blood glucose
- Urine Analysis : Albumin, sugar, microscopic examination

If the semen analysis report reveals any abnormality, the patient is referred to Post Partum Centres / Maternity Homes for further evaluation.

If the semen report is normal, the woman needs to be clinically evaluated by a gynaecologist. The patient should be referred to Post Partum Centre/Maternity Home.

At the secondary level (Post Partum Centre / Maternity Home)

At the Post Partum Centre, the gynaecologist, after examining a woman will conduct the following investigations to find the cause of childlessness

Routine laboratory investigations

- Blood group: ABO Rh typing
- VDRL
- Blood glucose both fasting and post glucose
- Urine Analysis : both fasting & post glucose

Hysterosalpingography

Hysterosalpingography (HSG) is the process wherein a water-soluble dye is injected into the uterine cavity to check for tubal patency.

HSG helps to identify tubal blocks, hydrosalpinx, tuberculosis, etc.

HSG is performed within a week from the last day of the menstruation.

Ovulation tests

These tests are done 6 months after HSG.

Basal body temperature: The woman records oral temperature daily from the 1st day of menses on waking up before going to the toilet. The temperature is charted daily for 3 to 4 cycles.

In the ovulatory cycle, basal body temperature is biphasic. There is a sharp drop of temperature of 0.50F at the time of ovulation followed by a sustained rise of 10F during luteal phase (progesterone effect).

Tests for Cervical Factors

Fern Test: This is an indirect evidence of ovulation. The cervical mucus is collected, smeared on a glass slide and dried for 15 minutes. The slide is examined under high or low power of microscope.

Due to the oestrogenic effect, the cervical mucus shows a fern like pattern. Due to oestrogen, the cervical mucus starts showing ferning pattern by the 5th or 6th day of the menstrual cycle and reaches the maximum 24 to 48 hours before ovulation. 24 to 72 hours after ovulation, due to effect of progesterone, the cervical mucus shows a beaded cellular pattern and by the 22nd day of the menstrual cycle (MC), the ferning pattern is completely absent.

If the ferning pattern is seen by the 22nd day of MC, it means ovulation has not occurred.

Spinnbarkeit: The cervical mucus has the property of elasticity and withstands stretching into a thread up to 6 cm whereas the cervical mucus under the influence of progesterone cannot withstand the tension and the thread breaks. If the thread breaks, it means that ovulation has not occurred.

The cervical mucus is placed on a slide and covered with a cover slip. The cover slip is pulled apart to see whether the cervical mucus stretches or not.

Postcoital Test: This test is performed to check for cervical mucus insemination.

At the presumed time of ovulation, the couple is asked to have sexual intercourse within 8 hours (preferably 2 hours). After this the woman has to go to the laboratory for the test. The cervical mucus is aspirated by a plastic tube and placed on a glass slide. The slide is examined. If there are more than 5 motile sperms, the test is positive.

This test, however, is not very reliable. Poor or negative result could be because of faulty intercourse, oligozoospermia or poor timing of test or immunologic childlessness.

The lack of reliability of these tests for ovulation and cervical factors makes more intrusive methods unavoidable.

Premenstrual D & C with diagnostic lap: This is done when all the above tests are normal or HSG shows abnormal findings. This test is useful to study the patency of fallopian tubes, ovarian status and peritoneal factors like adhesions, endometriosis. However D & C may introduce infections. In case of suspicion of tubal and uterine factors, endoscopy laparoscopy and hysteroscopy is advised.

If the above investigations fail to achieve pregnancy, the couple if referred to teaching hospitals for further investigation.

At the tertiary level (Teaching Hospital)

- Testicular biopsy is done in cases of azoospermia or severe oligozoopsermia to identify faulty spermatogenesis.
- In a man who shows oligozoospermia, there is a need to look for varicocoele.
- Vasography is done if testicular biopsy in a man with azoospermia is normal.
- *Hormonal assays in male*
  - FSH
  - LH
  - TSH
  - Prolactin
  - Testosterone

- *Hormonal assays in female*
  - FSH
  - LH
  - TSH
  - Prolactin
  - Testosterone

- *Immunologic test*
  - The Sperm - mucus Slide Test is done in couples who show poor post coital test

Management

Management of childless couples depends on the cause. Once the cause is identified and treated appropriately, the couple will be successful in conceiving. First step in management is to give information on fertile period and sexual intercourse. Counselling may also need to be provided about these aspects.

Special Treatment

- Artificial Insemination
- Invitrofertilisation and Embryo transfer (IVF)
- Gamete intrafallopian transfer (GIFT)
- Adoption

Artificial Insemination (Husband)

The semen is collected and placed at the external os for a few days at the time of ovulation . This is done for 3 to 6 cycles. It is indicated in case of oligozoospermia.

Artificial Insemination (Donor)

Semen in collected from an unknown healthy donor or from a semen bank and instilled at the external os for few days at the time of ovulation. This method is indicated in cases of azoospermia or severe oligospermia.

Invitrofertilisation and Embryo transfer

This method is adopted in couples who have irrepairable tubal damage, severe endometriosis, oligozoospermia and unexplained fertility. The ovum is fertilised by the sperm under laboratory conditions. The fertilised ovum/embryo is allowed to undergo cell division till it reaches the 4 to 8 cell stage. At this point the embryo is then transferred into the uterus.

Gamete Intrafallopian Transfer

The ovum and sperms are placed into the lumen of the fallopian tube through a catheter at the time of laparoscopy or minilaparotomy. This method is adopted in unexplained childlessness, endometriosis, male subfertility, failed donor insemination, failed induction of ovulation and premature ovarian failure.

Adoption

When a childless couple fails to conceive even after treatment for two years, the couple should be advised to adopt a child. Adoption may be the only way out for a couple with unexplained fertility, who have failed to conceive for three years. But the final decision for adoption should be left to the couple.

Procedures like IVF and GIFT are complex and not available everywhere. Even if they are available, they are expensive methods.

A few of the adoption centres in Mumbai

Family Service Centre, Eucharistic Congress Building No.111, Convent Street, Mumbai - 400 001.

Tel.No. 22021432 / 22828862

I.A.P.A. , Canara House, Room No.7, Ground Floor, Mogal Lane, Matunga (West), Mumbai - 400 016. Tel.No. 22043758
Shraddhananad Mahilashram, Maheshwari Udyan, Matunga, Mumbai - 400 019. Tel.No.24012552 / 24010715
Vatsalya Trust, Survey No.1285, Near Kanjoor Police Station, Kanjurmarg (East) Mumbai- 400 042. Tel.No.25782958

Social Implications of Childlessness

Childlessness has never been a priority area for health planners, although medical professionals and quacks have been exploiting it for their personal gains. Childlessness can profoundly disturb the personal and social life of a couple in a number of ways

- Sense of personal failure
- Constant harassment by in-laws, parents, friends, and others
- Fear of insecurity and loneliness in old age
- Loss of ambition and drive
- Fear of loss of property rights

The order of severity for men and women varies, and broadly they can be visualised as

Men	Women
• Loss of ambition and drive.	• Constant harassment by in-laws, parents friends and others.
• Fear of insecurity and loneliness in old age.	• Sense of personal failure.
• Fear of loss of property rights.	• Fear of insecurity and loneliness in old age

An childless couple is a unit and should naturally be treated as one, instead of labelling either the husband or the wife childless. But the reactions of the two to the stress imposed by the problem are not the same. To a considerable extent, these differences are culturally determined.

Men feel

Careless: "It hardly matters to me; she is free to do whatever she wants by way of treatment."

Hesitant: "Let us leave it to fate (any investigations may recoil on me)."

Aggressive: "It is all her fault. I am not impotent. But for my patience, my parents would have brought another wife for me by now."

Women feel

Helpless: "My in-laws object to my going to the doctor again and again. Who will do the housework? They want me to consult some dai instead."

Threatened: "You won't even get pregnant. We must find another wife for our son."

Self-pity: "I have to take all the blame and suffer. Even if the fault is with my husband I can't declare it. It is the same with all women."

Consequences of childlessness

- Marital instability (28%)
- Physical violence by husband as a response to childlessness (70%)
- Loss of relationship
- Isolation and stigmatisation of childless women
- Woman herself avoids ceremonies (52.1%)
- Women considers herself inauspicious for ceremonies (19.4%)
- Lack of social security and support
- Fear of extinction of family lineage
- Negative feelings: depression and grief, jealousy and anger, guilt and worthlessness, stress
- Loss of important body function

(Source : Veena B Mulgaonkar ; ***A Research and an Intervention Programme on Women's Reproductive Health in Slums of Mumbai,*** *Sujeevan Trust, Mumbai, undated.)*

Childlessness and Violence

- Verbal abuse & quarrels (55.1%)
- Physical violence (5.3%)
- Sexual abuse forced sex within marriage (3.6%)

Counselling

The intimate nature of the problem makes counselling difficult. The questions that need to be asked from a childless couple are often as disturbing as the idea of childlessness. For the woman it is not just a medical problem, it affects her whole attitude to life and the purpose of marriage is almost completely destroyed. Without children she will be ostracised from a whole section of social communication which she has taken for granted so far. Great care must be taken to dispel any idea that the position is hopeless. The woman will have to face a series of investigations and the reasons for each one of these must be explained to her and the subsequent results discussed. It is very important that this explanatory process is not hurried. Time should be required to allow the patient to adjust to the problem. The term 'childlessness' should be used sparingly and there is justification for the use of euphemisms in the early stages. Very often it takes several months before a couple accepts the position and begins to cooperate actively with the medical team. The members of the team must not be over-zealous in giving reassurances but should accept the feelings of the couple as normal, however they are expressed.

When the problem lies with the male partner the position can be more difficult. Traditionally, childlessness in a marriage has always been regarded as the 'fault' of the woman. For the male to be told he is infertile is devastating. His role as the dominant partner is gone and his ego destroyed. The sexual relationship is likely to be upset. There are apt to be periods of impotence due to the effects of psychological stress. This is a time when the question of donor sperm should not be discussed. Time must be allowed until the couple can view the position with some degree of objectivity.

What the Health Worker can do to help the Childless Couple

- Provide emotional support to the couple. Convince them that some solution can definitely be found, and the health care system is ready to help them
- Protect the couple from falling into the hands of quacks and unscrupulous healer-exploiters.
- Motivate the couple, particularly the husband, to go through some essential screening tests to find the cause of their childlessness.
- Ensure proper compliance during the treatment phase - often extending through months and years. Sperm formation in a man takes 74 days to complete, the egg or ovum matures only once in a month (or menstrual cycle) and the baby takes 9 months to be ready for birth. There is no way to hasten this process. A common mistake often committed is that the doctor changes the treatment too often, or the patient changes doctors too often.

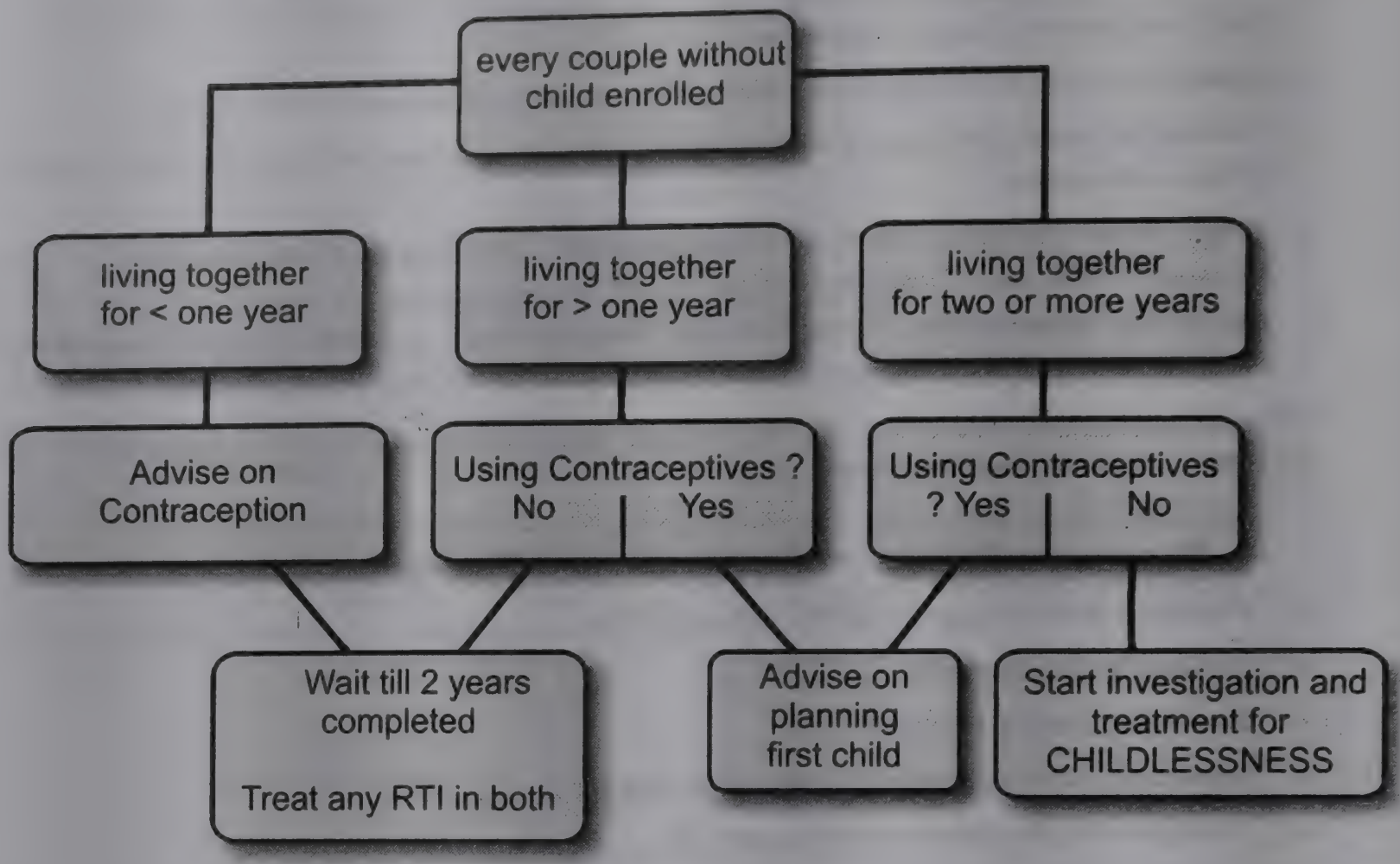
Where no treatment is likely to help, the couple should be counselled not to waste any more time and money. Help them decide on alternatives like adoption.

Recommendations for Prevention and Management of Childlessness

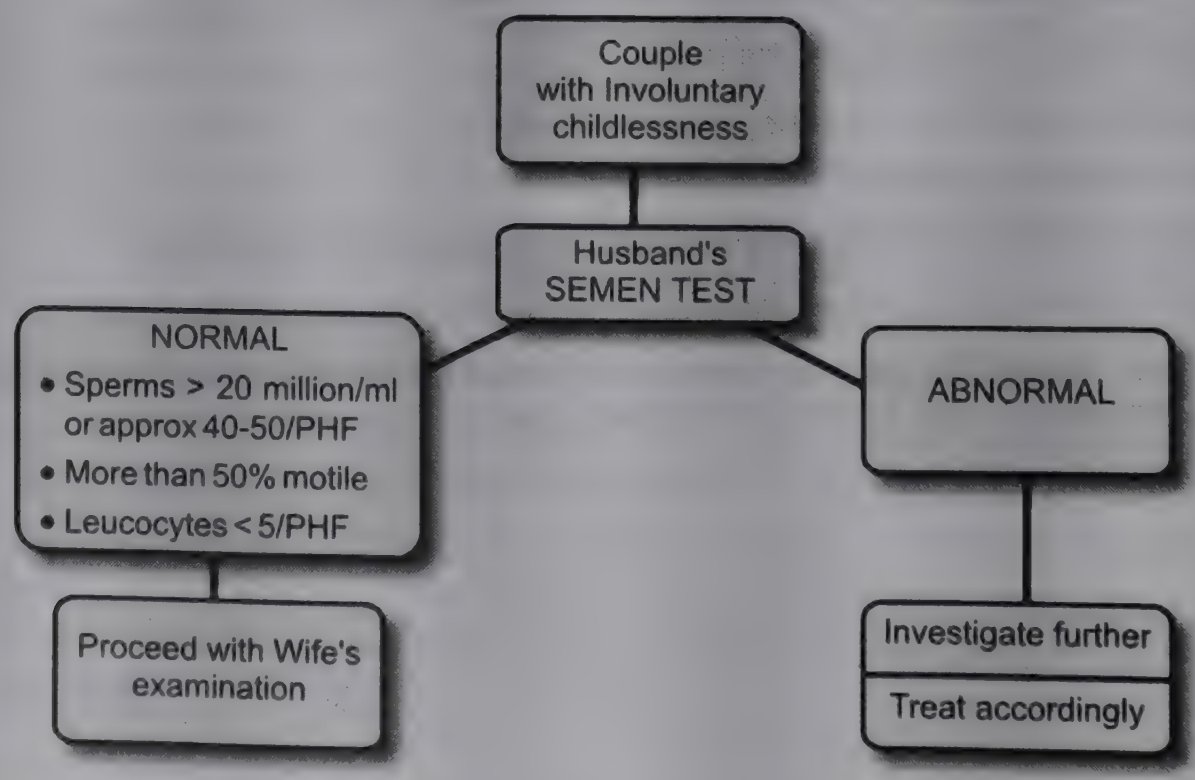
- Prevention and management of RTI, including STDs
- Services for safe abortion
- Services to promote safe motherhood
- Prevention and management of unwanted pregnancy
- Linkages with tuberculosis control programme
- Improved coping mechanisms
- Training of community health workers and other health care providers
- Overcoming cultural barriers and removal of stigma of childlessness by enhancing understanding about the condition through awareness programmes and developing peer groups
- Enabling adoption and fostering
- Improving women's self-esteem, empowering them and enhancing their gender roles
- Strengthening existing support systems and creating new ones
- Managing psychological and sexual problems and effective counselling
- Screening and evaluation of the mental health of childless couples
- Counselling for improving marital relations
- Supportive counselling
- Sexual compatibility guidance
- Addressing problems related to costs involved in management of childlessness
- Addressing ethical issues, issues regarding human dignity related to childlessness

*(Source : Veena B Mulgaonkar ; **A Research and an Intervention Programme on Women's Reproductive Health in Slums of Mumbai,** Sujeevan Trust, Mumbai, undated.)*

MANAGEMENT OF COUPLES WITHOUT A CHILD



PRELIMINARY SCREENING OF CHILDLESS COUPLE



INVESTIGATING THE HUSBAND WITH DEFICIENCY SEMEN QUALITY TO FIND THE PROBABLE CAUSE

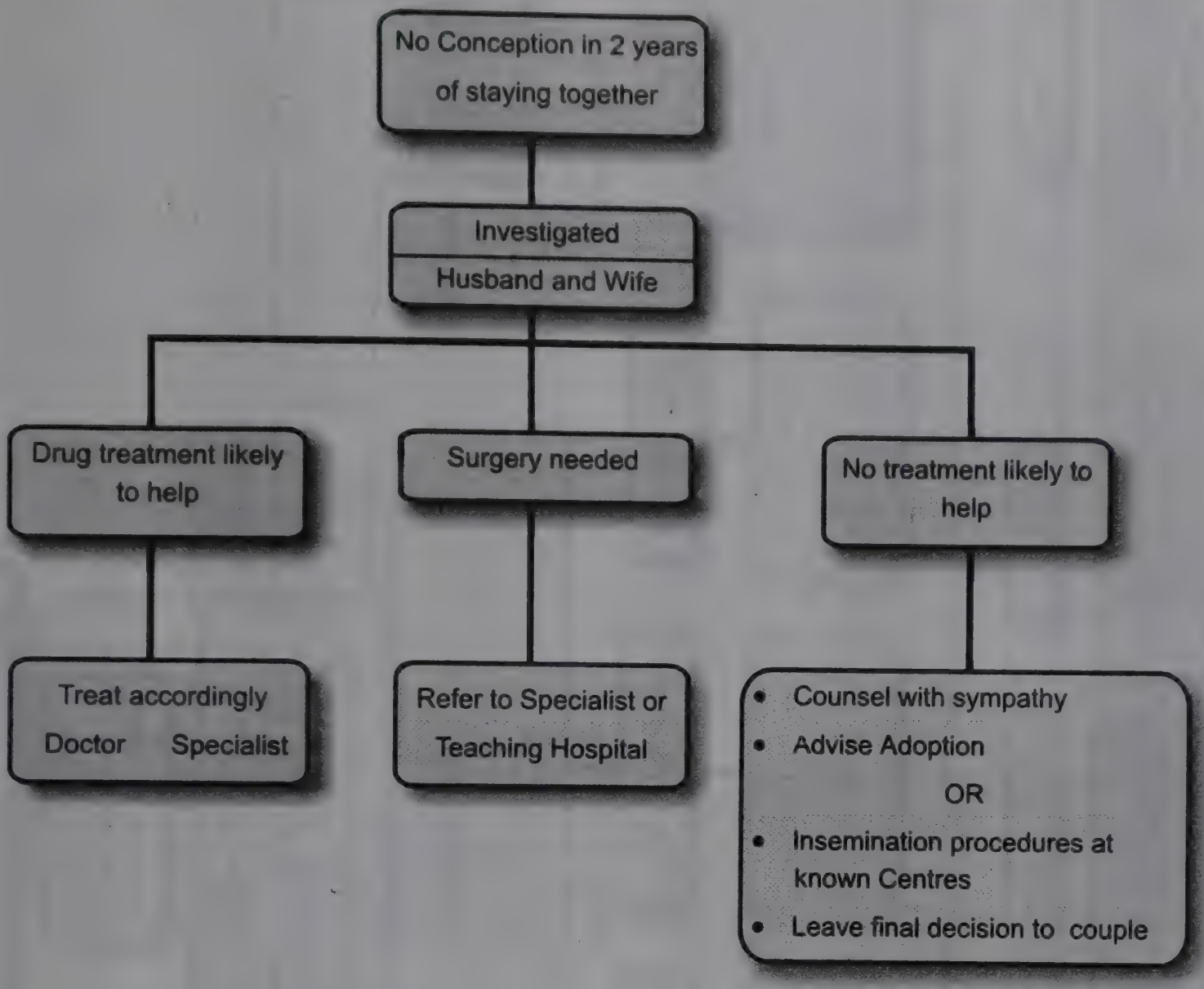
Semen examination shows absent/low sperm count and motility. Proceed further as shown below

INVESTIGATION	WHO CAN DO IT & WHERE	COMMON CAUSES
LEVEL- I Causes which can be known by simply QUESTIONING The husband (History taking)	Male health worker, Male doctor (Health Post, Dispensary, Hospital)	• Excessive use of tobacco, alcohol, other intoxicants. • Exposure to direct heat: working near open bhatti, furnace, boiler. • Viral fevers in the past: mumps, small pox. • STI any urinary problem with urethral discharge, genital ulcers (history of such contacts). • Unsatisfactory marital relations - unconsummated marriage, infrequent intercourse, mostly staying away from wife at a distant work place
LEVEL-II Causes which can be known By simple PHYSICAL EXAMINATION	Male doctor with short training (Health Post, Dispensary, Hospital)	• Hypogonadism - poorly developed secondary sex characters. • Varicocele. • Testicular atrophy. • Maldescended testes. • Congenital absence of vas. • Infections - prostate, epididymis
LEVEL-III Causes which can be known only after SPECIAL LAB TESTS	Specialists (Referral or Teaching Hospitals)	• Hormonal disorders. • Immunological Childlessness. • Rare genetic causes.

INVESTIGATING THE WIFE AFTER THE HUSBAND'S SEMEN EXAMINATION HAS BEEN FOUND TO BE NORMAL

PROCEDURES	WHO CAN DO, AND WHERE	POSSIBLE CAUSES
LEVEL- I Causes which can be suspected by simply QUESTIONING the woman (history taking)	ANM, lady health worker, lady doctor (at patient's own house, Health Post, Hospital)	**1. Related to marital life** • Frequency and timing of intercourse. • Feeling of satisfaction, orgasm, pain during intercourse. • Reproductive Tract Infection: vaginal discharge, itching, ulcers, swelling. • General health: weakness, tiredness, depression, anaemia, under-weight, over-weight. **2. Related to menstrual cycle** • Age at menarche. • Regularity and duration of cycle. • Amount/pattern of flow. • Pain during periods.
LEVEL-II Causes which can be detected by examining the patient	Trained lady doctor, Gynaecologist (Referral Hospital)	**1. Fallopian Tube Patency** • Rubin's Test/Diagnostic Laproscopy. • PV for PID, endometriosis etc. **2. Ovulatory Profile** • Ultrasonography • Endometrial biopsy (rarely) • Hormonal estimations: FSH, LH, Prolactin, Thyroid. • Bacteriological cultures: RTI, STD, others. • Immunological tests
LEVEL-III Causes which can be detected only through sophisticated lab investigations	Specialists (Teaching Hospitals)	

OUTLINE OF TREATMENT AFTER INVESTIGATIONS HAVE PROVIDED SOME IDEA ABOUT THE NATURE OF CHILDLESSNESS



References

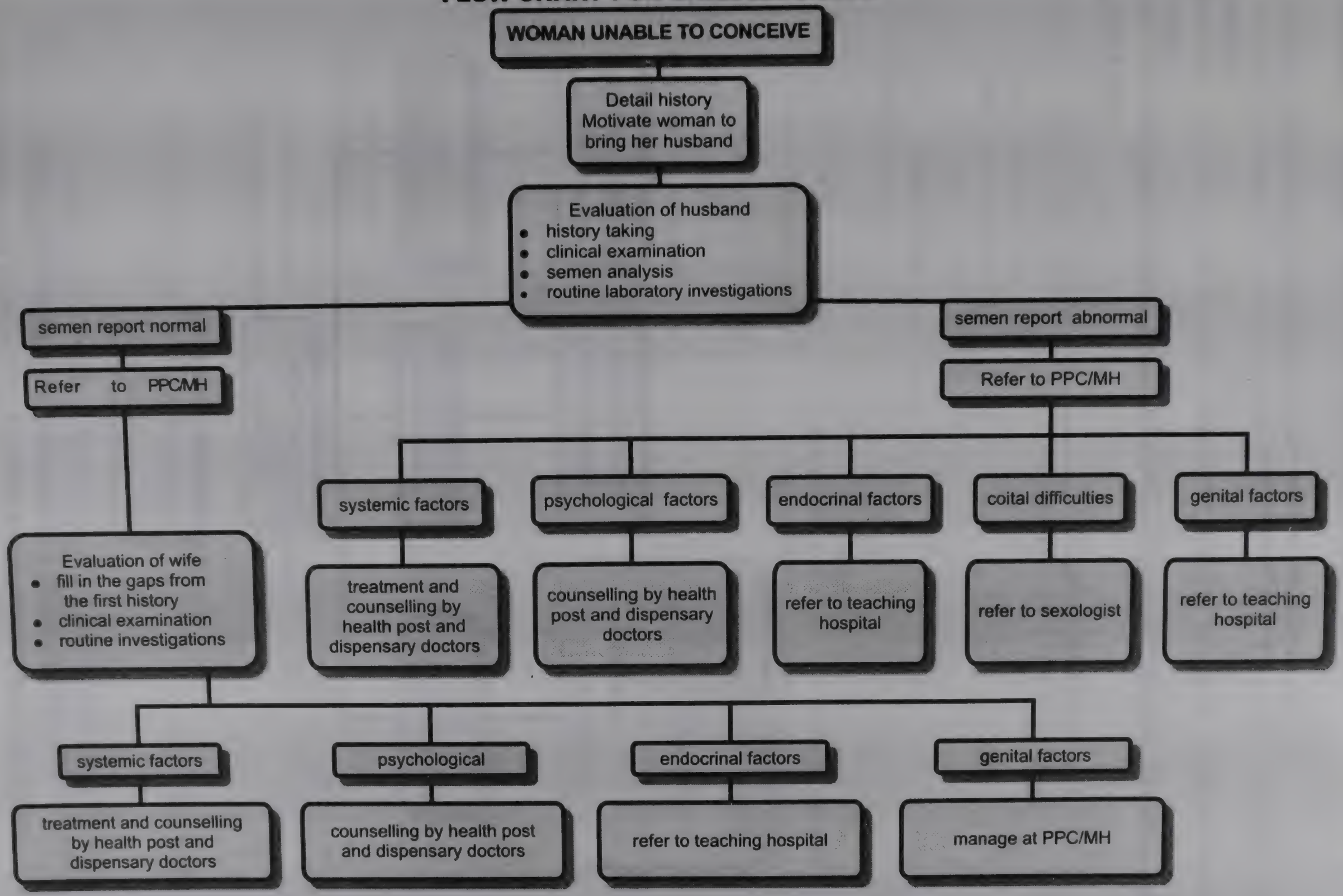
Dawn C. S. (1994), **Textbook of Gynaecology and Contraceptives,** (4th edition). Published by Srhrimati Arti Dawn, Kolkatta.

Govan A.D.T., D.M. Hart, R. Callander (1992), **Gynaecology Illustrated,** (4th edition). Published by Churchill Livingstone.

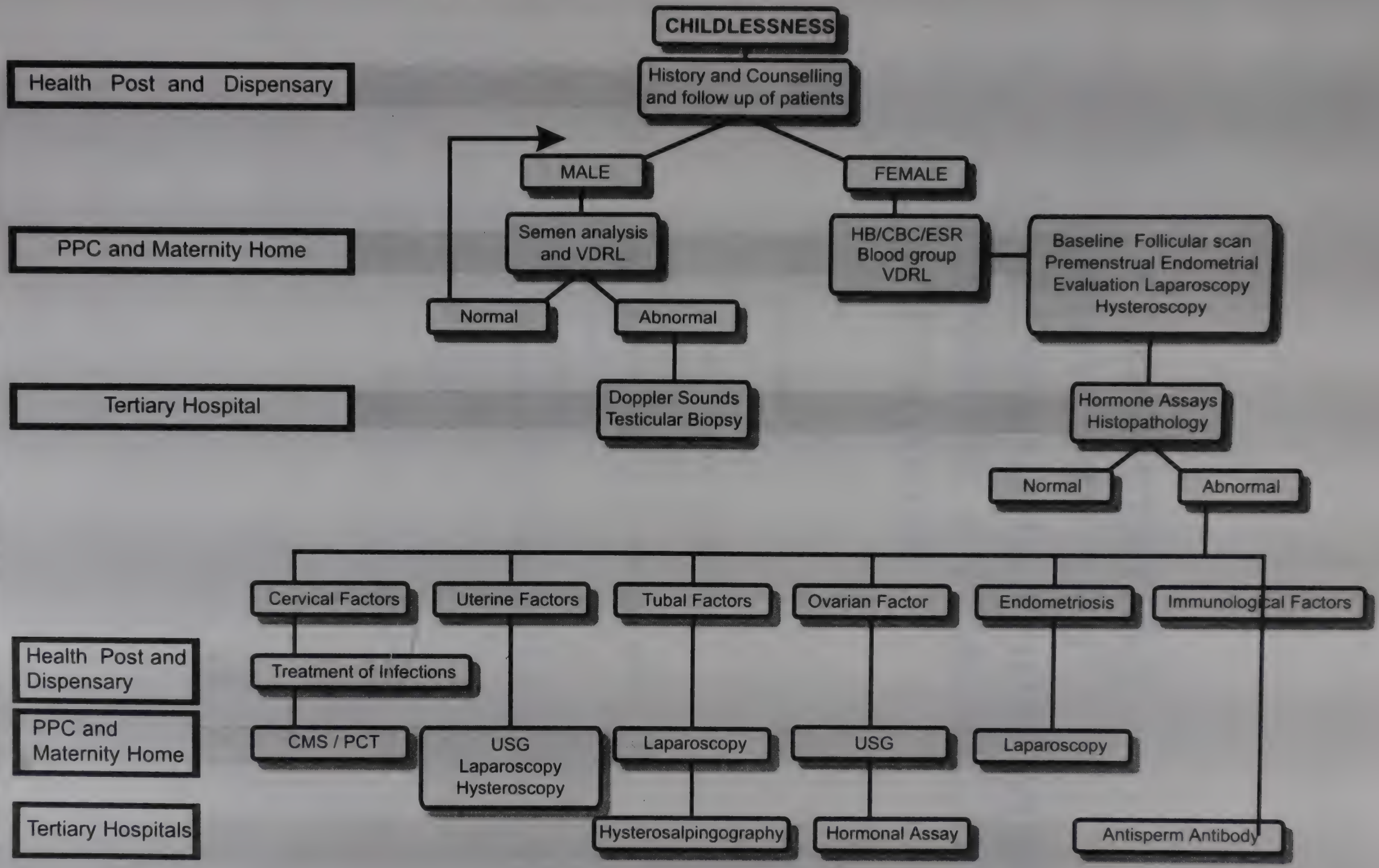
Indian Institute of Health Management Research (1998), **Understanding Reproductive Health - Operationalising Reproductive Health Management Development for Reproductive Health Programme,** Jaipur.

Contributors - Dr. Sharad Gogate, Dr. Usha Ubale, Dr. Padma Shetty

FLOW CHART FOR CHILDLESSNESS



LEVELS OF TREATMENT FOR CHILDLESSNESS



Handout 11

CONSULTATION PROCESS AND COMMUNICATION WITH WOMEN: A PRACTICAL APPROACH

Contents

- History Taking in Gynaecology
- General Guidelines
- Various Aspects of a Woman's History
- Examination
- Investigation
- Management, Reassurance, Motivation, Information
- Follow up
- Referral

History Taking in Gynaecology

History taking is the most important part of the patient-doctor interaction. In history taking of a patient with gynaecological problems, apart from general information, details of marital and sexual life are also sought. This can be extremely embarrassing for a woman to share, so the provider has to take special care to make history taking a successful task.

Ancient Greeks believed that hysteria was related to a disease of the womb (Greek: hystera, a womb). A woman discussing gynaecological problems will often show signs of distress - embarrassment, fear, and shame. Hence clinicians need to be aware of and sensitive to the needs of women.

General Guidelines

Need for Privacy

The consultation should be held in a closed room. Permission should be sought for the presence of a nurse or a female attendant. In the existing situation of a health post where there is no separate consultation room privacy can be achieved by making the woman sit closer to the table and talking to her softly.

Establishing Rapport

The patient needs to be made comfortable right from the beginning of the consultation. Doctors need to maintain eye contact with the patient while asking her to sit down or while questioning her as this may help the patient to develop trust and confidence in the doctor.

Simple questions like age, number of children, occupation, income, and duration of marriage could be asked at the beginning of the session. Once rapport is established, one can start asking details about contraception, major illnesses, menstrual history, abortions and sexual problems.

Time and Patience

The woman should be allowed to tell her own story before any attempt is made to elicit specific symptoms.

Having patience to listen to the patient's problems is the next important thing. Women communicate more through their silences and non-verbal communication like body language, than through words. Over generations women have been socialised to be embarrassed and ashamed about their bodies and remain silent about every thing related to them. With this cultural background it appears natural that a woman will have difficulty in talking about her symptoms related to reproductive and sexual health. Hence giving her time to express her problem and observing her non-verbal communication becomes crucial and can save health care providers from getting incomplete or incorrect information.

Types of Questions

It is important to ask open-ended questions to get the exact information and experience of a woman's problem. To know what are open-ended questions and their importance in history taking, first let us understand what are the different types of questions and their uses.

Closed questions These require a short yes/no/number as an answer or a pre-coded answer.

Examples

- *Are you married?*
- *Do you have problems when having intercourse?*
- *How many years ago did you get married?*
- *Do you have any other problems?*
- *What is the colour of the vaginal discharge? is an open question but it becomes a closed question when immediately followed by: Is the discharge yellow in colour? Is the discharge watery?*

Respondents are not encouraged to formulate their own answers and therefore do not have a chance to express what they think and feel. Closed questions should be avoided in history taking on matters that are personal and intimate.

However, sometimes at the beginning of history taking or when the patient is shy, closed questions can make her feel safe. Also when you have not understood the answer given by the patient, a question paraphrasing what the woman said and asking if this interpretation is correct, is also an appropriate use of closed questions.

Example

If I understand you correctly, you are saying that your periods were regular till last year, and then you got MTP (thaili saaf) done, after which you are having heavy bleeding?

Open questions These invite respondents to give their ideas, feeling and opinions in their own words.

Examples

What other medicines or treatment have you taken?

What do you feel about the treatment in the hospital?

What do you feel about controlling the size of your family?

Leading questions These suggest a certain answer or make it easy for the patient to agree with what you are saying. They lead the patient in a certain direction.

Examples

What do you think is good about breast milk? (Implies that breast milk is good and makes it difficult for the respondent to say what she thinks is not good about breast milk)

Do you think you had problems with Copper T because it was put in soon after MTP?

Don't you think having so many children is not right?

Do you think the bleeding occurred because you travelled so far in the bus?

Judgments These often have the same effect as leading questions. They set the scene and let the patient know what the health provider finds good or bad. Often the health care provider is seen as powerful so it is better to avoid statements that indicate what he/she finds good or not so good.

Examples

What? You have four children already! This is not right.

Good you spaced your children well.

It is very good that your husband does not mind using condoms.

You are not married and you have missed your periods!

Probing questions These invite the respondent to talk in more detail about an issue. They are the most important type of questions during history taking. Health providers may find these the most difficult to use in the beginning. Probing questions often begin with how, when, who or what.

Examples

You had heavy bleeding when using Copper T. Can you tell me a bit more about what happened?

You say you did not come for the follow up because you had family tensions. What family problem did you have?

Your family has given you pills that made you giddy. What did your family give the pills for?

You say you had discharge. When did you start having this problem? What did it look and smell like?

Many women say they feel ashamed about talking about a smelly discharge. How do you feel about this?

se of Local Terminology

culture of silence has been established around a woman's body. Health professionals are part of that culture and art from technical jargon around reproductive and sexual health, they are not used to speaking about these issues ing local terminology.

ne woman in the PID study expressed her problem thus: *"Yes, I told the doctor. But she did not listen to everything. he understood that something is wrong, more or less."*

was telling the doctor that, 'Paani Bahar Girta Hai', but she did not seem to understand," said one childless woman in e PID study. She was trying to explain her husband's problem of premature ejaculation during intercourse.

hese examples bring us to an important aspect of history taking or communicating with patients, that is knowing the cal terminology that women use to describe their problems. For example. *Angawarun jata, mahina, masik, jata hai or ata nahi,* for menstrual cycle, *laghwichi jaaga* for genital area and *aadmi ka pani* for semen.

a woman is asked to describe the type of white discharge, one has to provide her some words like whether it is *paatal, patla r jaada, mota* to describe thin watery or thick discharge or whether it is curd like or like the white of an egg.

o describe the quantity one needs to ask the woman whether she needs to use a pad or whether her clothes get oiled or whether it is in clots *(gatha)*.

Onset of a Problem

Women may have difficulty in remembering the exact dates and days of the onset of their problem, but many times hey can vividly remember the events before the onset of the problem.

Examples

'White discharge problem started right after the marriage' or *'after the second delivery' or 'it was sticky and yellow after the operation'.*

'Menstrual irregularity started after my abortion' or *'TL'* or *'after my third child started going to school.'*

The health provider has to be patient to calculate the exact duration of the onset of the problem and then confirm with the woman by paraphrasing what she has said before recording it.

Example

If I understand you correctly you started having pain during intercourse after your second delivery and you said that your child has just started going to school, so that means that you have been having this problem for the last three years?

Believing in Women

Many times problems related to menstruation or white discharge are assumed to be part of a woman's life and she may generally not complain about them. Health care providers need to be particularly aware of this fact. But if these problems are neglected they may result in further complications. Therefore if a woman mentions that her periods are not regular, it is important to ask her questions and probe further.

Sometimes it is difficult for a woman to convince the doctor about her problems, so it is important that the doctor gives her a patient hearing and believes in what she is saying. When a women complaints of *takleef* after the insertion of an IUD it is absolutely essential to check her rather than simply saying *'all women have this problem in the beginning'* or *'you are saying it, because you want to remove the IUD.'* Because Copper T is a major family planning target method, women's problems may not always be heard and taken seriously.

Example

During the communication observation exercise done at one of the Gynaecology OPDs, a woman-doctor interaction was observed and the observation reports state that a woman complaining of heavy discharge and pain during intercourse, had a tough time convincing the doctor that she needed to remove the Copper T as it was causing her

problems. She was asked to get proof that she had completed three years of insertion. The woman then went home and got the three-year-old papers, which had the date of Copper T insertion. When she was finally examined she was found to have an ulcer on the cervix. The doctor then asked her why she did not come earlier for a check up.

Various Aspects of a Woman's History

Obstetric History

Record the number of pregnancies followed by the number of abortions eg 5 +2.

Note the year of each pregnancy, the type of delivery, any history of trauma, excessively long labour or any other complication.

To get accurate information on the number of pregnancies one can avoid reacting or exclaiming on the answers provided by the woman.

Sometimes the moment a woman says she has more than three children health providers express distress over this fact and start advising her about family planning rather than concentrating on the complaint for which she is visiting the clinic. The health providers should first try to manage her current health problem. Discussion pertaining to limiting the family size could be done at a later stage.

Reacting, exclaiming, advising or making judgmental comments during history taking can affect the process and may make the woman defensive. She may then give the answers that the provider wants to hear rather than the real facts. Instead a health provider can encourage her to share correct information by showing genuine concern for her current complaints.

Once rapport is established and the woman is satisfied with the treatment being given for her current complaints she may develop trust and be ready to listen to the other advise which the doctor may want to give.

General History

The gynaecologist should know if the patient has ever suffered from tuberculosis, cardiac or endocrine disease or psychiatric illness. Previous surgical procedures should be noted.

Gynaecological History

Previous gynaecological treatment is best learnt about from clinical records if they are available. Patients' recollections may be incorrect or misleading.

Menstrual History

This can vary from patient to patient and still be within normal limits. Vague complaints are unlikely to be due to gynaecological problems.

Menarche

This is the age of onset of menstruation and varies between 10 and 16 years.

Rhythm of Cycle and Duration of Flow

These are conveniently expressed together as a numerical fraction. Thus 5/28 means that the patient menstruates for 5 days every 28 days.

Volume of Blood Loss

This can vary between 30 and 200 ml. Blood should be liquid, but parous women may pass small clots. Large clots mean that the loss is abnormal and the fibrinolytic system cannot break down all the blood that is shed.

Complaints of Pain

The patient is asked where she feels the pain, whether it is intermittent, related to the period or continuous. The ordinary pain of menses is felt in the back, lower abdomen and down the thighs. It must be distinguished from other abdominal causes of pain such as appendicitis.

Backache related to menses ('like a steel plate pressing inwards') refers to the sacral area and should be distinguished from loin pain of renal disease that can be exacerbated by the congestion of menstruation.

Pain associated with intercourse (dyspareunia) may not be mentioned spontaneously, and the doctor should ask if pain is caused or worsened by intercourse.

The severity of pain can be judged to some extent by its effect on the patient's behaviour.

Sexual History

Taking sexual health history is very important as this plays a vital part in the presentation and treatment of sexually transmitted infections. It is important to know about pain during intercourse as well as whether her partner/s have any signs or symptoms of STIs. A woman may have the infection and yet be asymptomatic.

But in our culture discussing sex and sexuality is taboo. However, if the woman is assured of confidentiality, she would be willing to speak. Some women may be shy, embarrassed or ashamed to talk about these subjects, while others may feel that health care providers would make judgements about them like they must be indulging in immoral behaviour.

Questions should be asked in a situation where no one else can overhear the answers. The health care provider should be non-judgmental and respectful towards the woman as this will help to establish rapport. The woman should be assured that the information will be kept confidential and it should be explained to her that the questions are essential for her health care.

Some of the questions that can be asked to get information about a patient's sexual health issues are

- Do you experience itching or pain in the groin area?
- Do you experience lower abdominal pain?
- Do you have pain during intercourse?
- Do you/your partner experience pain during urination or do you have an urge to urinate frequently?
- Do you/your partner have a sore/blister/boils on the external genital?
- Have you/your partner had these in the past?
- Do you/your partner have more than one partner?

Examination

Examination of the breasts

A gynaecological examination provides a suitable opportunity for examining the breasts also. Signs of pregnancy or lactation may be observed or a lump may be palpated. The breast is a much commoner site of cancer than the genital tract.

The examination can be made with the patient lying on her back. The breast is gently but thoroughly palpated with the fingers, and the axilla is also palpated.

Abdominal Examination

No matter what the patient's complaint this must also be done. Many gynaecological tumours form large swellings or an undisclosed pregnancy may be present. Always examine the upper abdomen. Be certain that the bladder is empty. Instruct the patient to tell you if you are hurting her.

Pelvic examination alone might not reveal pregnancy if the unsuspecting examiner were to inadvertently palpate the soft and elongated cervix without feeling the enlarged corpus

All the classical techniques of inspection, palpation, and auscultation (for a foetal heart) are advised, but the most important is gentle palpation with the flat of the hand to detect solid or semi-solid tumours.

The examiner must bear in mind the various intra-abdominal structures that may give rise to swellings.

Inspection may show the characteristic shape of a large ovarian cyst. The outline is rounded and uniform, the skin is stretched and a fluid thrill may be elicited.

If ascites is present (this means that the cyst is probably malignant) the outline tends to be cylindrical, with some flattening at the top. The umbilicus is averted and the percussion note is dull in the flanks but tympanitic above because of the upward floating of the intestines.

If the patient is turned on her side and the percussion is repeated after about 30 seconds the dull and tympanitic areas are reversed - 'shifting dullness'.

The very fat abdomen is not uncommon in gynaecology. Palpation is extremely difficult and examination under anaesthesia and more elaborate investigations will be necessary (ultrasonography, X-rays, laparoscopy if feasible).

Examination of the Vulva

The dorsal position is most convenient both for the patient and the doctor although some prefer the patient to be in the lateral position. During palpation, the condition of the labia, clitoris and surrounding skin should be noted. Thus excoriation suggests irritating discharge and pruritus, purplish discoloration might be a sign of diabetes.

- A single finger presses on the perineum, avoiding the sensitive vestibule, and accustoming the patient to the examiner's touch.
- Urethral meatus and vestibule are exposed. Pressure from the finger will squeeze any pus from the peri-urethral glands.
- Bartholin's gland is palpated (on both sides). It is difficult to feel the normal gland.
- If there is room, a second finger is inserted and the perineal floor is palpated by stretching.

Internal Examination

Special care needs to be taken before and during the internal examination. The following points can help to make the woman feel comfortable and respected during the examination of vulva, vagina and bimanual examination

Women feel shy and scared of per speculum or per vaginal examination. A woman's fear and shyness can be reduced by explaining to her what examination is going to be done and why. She also needs some time to prepare herself mentally before she is ready for the examination, so it is important to give her some time and take her consent before examination.

A patient not only needs time for preparing herself mentally but also physically for the examination. She should be asked whether she is menstruating before the examination and it should be explained to her that she should come again if she cannot be examined during menses.

Ask her to pass urine before you do an internal examination. She may have to loosen or untie her garment or remove her underclothes. This needs to be explained to her before the examination and there is need to provide her with privacy to prepare before she lies down on the table. It is important to provide her with a sheet to cover her body. This will help to reduce her shyness.

Sometimes the gender aspect plays a crucial role during examination. A woman may not feel comfortable getting examined by a male doctor. It is important to explain to her that a male doctor is going to examine her. When the woman is not informed in advance, she feels extremely shy and embarrassed. This prevents her from taking a proper gynaecological position for the doctor to examine her properly. Sometimes women do not open their legs and this can further affect the examination procedure. It has been observed that at times the female attendants shout at patients or hit them on the legs as a way of telling them to take a proper position.

A woman needs to be told in a respectful and caring way to open up her legs or let her muscles loosen. This also requires time and patience.

nother way of helping the patient feel comfortable could be to hold her hand or allow her to hold the attendant's hand, she goes through some pain during examination. Through this kind of physical touch, caring and concern for the atient can be communicated.

ometimes it is important to explain to the woman on the examination table what one is seeing. But exclaiming, *"Oh, ny god! Look at this", "Oh, it is so bad", "Yeh Kya Kiya hai?,"* makes the patient feel uncomfortable, scared and erhaps humiliated. One needs to talk to the woman and keep an easy conversation going while examining her. If the octor observes a gentle, respectful, sensitive communication with the patient, the other staff members present will lso follow the role model. The clinician has great responsibility in establishing a role model for responsible and espectable behaviour by the rest of the staff towards the patient.

Steps of Vaginal Examination

The patient must empty her bladder prior to the examination. She is made to lie down in the dorsal position with the highs flexed along with the buttocks placed on the foot end of the table. Hands should be washed with soap and sterile gloves put on the examining hand (usually right).

Inspection: By separating the labia using the left two fingers (thumb and index), the character of the vaginal discharge, if any, is noted. Presence of cystocele or uterine prolapse or retocele is to be elicited.

Speculum examination: This should be done prior to the bimanual examination specially when the smear for exfoliative cytology or vaginal swab is to be taken. A bivalve speculum is introduced into the vagina vertically with the blades closed, after separating the labia by two fingers of the left hand. The speculum is to be rotated 90 degrees and the blades opened. The cervix and the vault of the vagina are inspected with the help of a good light source placed behind. Cervical smear for exfoliative cytology or a vaginal swab from the upper vagina if there is a discharge may be taken. The speculum is removed after the blades are closed and rotated vertically.

Bimanual: Two fingers (index and middle) of the right hand are introduced deep into the vagina while separating the labia with the left hand. The left hand is now placed suprapubically. Gentle and systematic examination is done to note

- Cervix: consistency, direction and any pathology
- Uterus: size, shape, position and consistency
- Anexae: Any mass felt through the fornix. If the introitus is narrow, one finger may be introduced for examination. No attempt should be made to assess the pelvis at this stage.

This technique needs practice. The external hand is more important and supplies more information. It is customary to use two fingers in the vagina, but an adequate outpatient examination may be made with only one finger. Very little information is gained if the patient finds the examination painful. In a virgin or a child only rectal examination should be carried out.

The doctor needs to see if a woman has pain during this examination. If she feels any pain it needs to be considered before doing any further examinations. Sometimes a woman's expression of pain could be misunderstood as fuss and it may be neglected. Therefore, one needs to be aware and sensitive to a woman's expression of pain.

One can understand whether a woman is experiencing pain by her verbal or non-verbal reaction (clenching teeth and fist, or holding on to the table tightly or holding the assistant doctor's or attendant's hand.)

Investigation

Women have an interest and a need to know what investigations need to be done and why. They need explanations in a simple language. If they understand why and what needs to be done, they will be well motivated to follow the instructions and get the investigations done.

If explanations are not properly given and women do not know what examinations are being done they may feel that the doctor is not looking after them properly. They may leave the treatment or investigation half- way.

Communicating the Results of the Investigations

If we want the patient to cooperate and participate in the treatment process it is important to explain the results of the investigations in a simple language.

Example

Communicating weight or the haemoglobin level to a pregnant woman may motivate her to improve her diet as she can see and understand the effect of diet on her weight or haemoglobin from her results.

Explaining findings of infertility investigations may help a woman to come to terms with her inability to conceive and can prevent her from going to quacks and spending money on unnecessary treatments and investigations.

Pap Smear

Pap smear should be done on all sexually active women at least once in their life time as a screening test for cervical cancer. This should be followed by a pap smear at an interval of 3 to 4 years.

It is necessary to avoid sexual intercourse or a vaginal douche for at least 18 hours prior to the procedure. Vaginal examination must not be done prior to obtaining a smear.

For this three smears are obtained as follows

- Portio Vaginalis with broad end of Ayre's spatula for cervical cancer.
- Endocervical canal with a cyto frush for endocervical cancer.
- Posterior fornix for cancer of the cervix, endometrium, ovary etc.

The smear is stained by the Papanicolaou stain.

Sometimes the sample may be inadequate because of faulty technique, rather than due to the paucity of cells. The test is repeated after one week.

Even if the pap smear report is normal, it still needs to be repeated at a one-year interval for two years and then every three years.

Pap smear may be inflammatory, showing specific infection or non-specific infection. Infection should be treated and Pap smear repeated after 6 weeks.

If the Pap smear report shows abnormality, malignancy or signs suggestive of malignancy then a cervical biopsy is done. The patient will then have to be referred to Post Partum Centre/Maternity Home for cervical biopsy.

Presence of endometrial cells needs further assessment at the Post Partum Centre/ Maternity Home.

Management

If we want the patient to follow the instructions and complete the treatment, it is essential that we explain the cause of her disease, the results of the investigations and what the treatment plan is and emphasise the need for her to complete the treatment.

Before prescribing any medicines or advising about investigations, one has to find out whether the woman can afford to take a particular medicine or get an investigation done. The clinician can help the woman find solutions to the problem of paucity of resources.

One also needs to tell the woman why certain tablets are being prescribed for her. Sometimes medicines are given to take care of probable side effects like preventing vomiting. It is important to prepare the woman for the side effects, otherwise she can get upset and stop the treatment completely.

Along with the medicines, some women may need to alter their life style or occupations. For example in the early stages of prolapse, a woman's husband or a family member can be requested to fill water to prevent deterioration. The reasons for this should be explained to her.

It is important and useful to ask the woman whether she understands the importance of the treatment and whether she foresees any problems or difficulties in taking the prescribed medicines and in following the advice.

Possible reasons for non-compliance could be

- No money to buy medicines or travel to the health care facility frequently.
- She may be going out of town.
- She may not have time immediately to go to another health care unit for referral.
- She may have tensions at home like violence by husband.
- She may not have anybody to support or nurse her.
- Her children may be small and she may have problems arranging for childcare.

The provider may need to help a woman find solutions to these problems. Both the clinician and the patient need to think of ways and means to minimise problems for the woman so that she can take the necessary treatment and preventive action.

Reassurance

Another aspect of a clinician's role in the management of the problem is to reassure the patient before she leaves the consultation room. This can be done by saying: "I have understood your problem and we will try to do all to minimise your problem." But at the same time the woman also should be told about her responsibility and participation in the treatment process like

- Completing the course of medicines.
- Coming in time for follow ups.
- Sharing about her personal problems relevant to her health.
- Following the advice and preventive behaviour and by expressing openly her inability to do the above.

Motivating Women to follow Treatment

Women will feel motivated to follow the advice given by the providers if the provider exhibits and expresses genuine concern for their health and is gentle and polite. If advice is given by assuming a position of power and with the attitude of *"I know the best and I have the power of taking decisions for the patients"*, women may feel powerless and lose confidence, becoming totally dependent on the provider.

To prevent this avoid using sentences that will reinforce women's perception of being powerless. Avoid saying

- *If you care for yourself, you won't be doing this or would be doing this.*
- *Who knows better? You or me? Who is the doctor?*
- *If you do all that I tell you, you will be all right.*

Instead, one can say

- *It will require both of us to make efforts for your well being, I expect your cooperation and only then I can do my job properly.*
- *Do you think you can do this? Is it possible for you to do this?*
- *Kindly tell me or feel free to express all your difficulties regarding your problem or the treatment.*
- *Do you want to tell me or ask me anything about this problem?*
- *Can you tell me next time what your husband or mother-in-law say about this?*

Information for Patients

Most of a woman's health problems are connected to her or her partner's reproductive system or genital area. Hence it is important to explain to the woman about the reproductive system after finding out what she already knows or whether she has got any wrong information from any other source. For example, during Focus Group Discussions in

the PID study, we found that most women do not know that they have ovaries which are important for conception, because traditionally a woman is believed to the a recipient of the man's semen. Her womb is considered to be the ground where seeds are sown for a new creation, so it is important to understand a woman's concept of her own body and the reproductive system. Once we know her perceptions and understanding we can relate our information to her concepts.

Information about the reproductive system can be given to all gynaecological patients in a group or individually using pictures or through exhibitions or flip charts.

Once women understand their own reproductive system and associated body processes, they may be better equipped to understand their specific health problems. Explaining probable causes of women's diseases will help them to understand the factors that contribute to their problems. Knowing about women's own perceptions about the cause of their diseases may give an important clue to the doctor. Further advice and the treatment, preventive action or behavioural change can then be based on what women know and believe

Some other important points to keep in mind while giving information to the patients

- Find out what the patient knows about the topic that you wish to discuss with her.
- Think about how much she needs to know at that particular point in the treatment process. (All information need not be given in the first visit).
- Decide which information can be given in a group and which can be given on an individual basis.
- Make the session as interactive as possible.
- Use simple language, avoid using medical jargon.
- Use local terminology wherever possible.
- Ask if the woman has any questions or doubts. Encourage patients to ask questions.
- Use visual aids wherever required.
- Explain the advantages and disadvantages of a particular medical procedure (abortion versus continuing the pregnancy). Give a woman time to make her decision. Encourage her to voice her doubts.
- Explain the reason for a particular procedure eg why it is needed to do a hysterectomy or D & C.
- Give the patient some reading material if available.
- Observe her non-verbal communication.

Follow up

There may be various reasons for a woman not coming for a follow up on the day she was called. Some of these are

- She may have fallen sick.
- Arrival of unexpected guests at her place.
- Someone at home was sick.
- She had an urgent family matter to attend to like death, marriage or festival celebration.
- Violence by husband/family member.
- She forgot the date.
- She may have gone to her native place.
- She could not get leave from work.
- The time was not convenient.
- She had a reaction from the prescribed medicines or heard something about the treatment or operative procedure from neighbours.

Instead of expressing anger one can begin by asking the woman what happened and if she had a problem coming on the day that she was supposed to. Such remarks encourage the patient to tell the real reason rather than telling lies to please the doctor or to prevent him / her from getting angry. Once she understands that you are concerned for her, she will discuss the real reason.

- Once the reason for a woman's failure to come for follow up is understood, one can attempt to resolve and deal with the situation accordingly. Encourage her to come for regular follow ups by suggesting solutions to her problems.

- For instance, if inconvenient timing is the problem, she could be called at another time according to both your convenience and hers or she could be referred to another unit. One should tell her that if she has a problem, she should express it now, so that a convenient day and time can be agreed on.

- If family members are creating problems, then one needs to talk to them. Such a case can be referred to field level staff for family level interventions and follow up.

- If she finds it difficult to remember the date, the next date should be communicated to her using certain local words or events by which she can remember the day.

- Explaining that follow up is crucial, the woman should be assured and convinced that it is important for her health.

If she is scared because of some information that she got from her neighbours, then the correct facts need to be explained to her to minimise her fear and encourage her to talk about her doubts.

If after this also she repeatedly fails to come for follow ups or if she repeatedly forgets, one can firmly explain to her the effects of non-compliance and that the irregular treatment is not useful.

Referral

Points to keep in mind before referring patients

- Know complete information about the referral centre where the patient is being referred.
- Make timely referrals.
- Rapport building with doctors at a referral centre is important. This can be done through joint review meetings, over the phone or by exchanging notes.

Consider the following factors when deciding on a referral centre

Time: How much time will the patient need to reach the referral unit from her house, what times she needs to be there and how long it may take.

Distance: Feasibility of the patient reaching the centre.

Cost: Money is important for the patient when he/she is from the lower socio-economic group.

If the patient is not able to afford the cost of treatment at a referral centre try to locate a voluntary organisation which gives financial assistance after discussing this with the patient and try to find out other solutions as well.

Explain the reason for referring, importance of attending the referral unit and its implications to either the patient or to the decision-maker in the patient's family.

- Be aware of the reasons and the difficulties that a patient may face for visiting the referral centre. Some of the reasons or barriers for not attending referral services are
  - Past negative experience with a particular referral unit
  - Not convenient in terms of cost, distance and time
  - Urgent work
  - Patient was unwell
  - Restrictions by family members

- One can attempt to deal with the problems of referrals by
  - Asking the reasons for not visiting and suggesting an alternative referral centre if necessary.
  - Checking whether the patient can go to a particular centre before making a referral or whether she has her own choice for a centre. At times, patients can have their own choice for referral.

- Filling the referral slip completely.
- Following up of referral is very important which can be done by asking for feedback from the patients and by communicating with the doctors from the referral unit.
-

References

Parulekar V (1997), **Differential Diagnosis and Management Options in Gynaecology and Obstetrics,** (1st edition). Published by Popular Prakashan, Mumbai.

BMC, LTMC & LSTM (1996), PID Research Study (Unpublished reports of In-depth Interviews).

Korrie de Koning(1996),. **Skills for Indepth Interviews** (Handout prepared for a training programme in the PID project)

Govan A.D.T., D.M. Hart, R. Callander (1992), **Gynaecology Illustrated,** (4th edition). Published by Churchill Livingstone.

Kistner R. W. (1986), **Gynaecology Principles and Practice,** (4th edition). Published by Year Book Medical Publisher.

Dawn C.S. (1994) **Text book of Gynaecology and Contraceptives,** (4th edition.). Published by Shrimati Arti Dawn, Kolkatta.

Novak (1996), Textbook of Gynaecology, (12th edition). Published by Williams Willkinim.

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SECTION IV
Overhead Transparencies

Overhead Transparencies

Contents

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- OHT 2 Understanding Women's Health
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Objectives

OHT-1.1

OBJECTIVES

- To improve knowledge about women's reproductive health problems.
- To understand the various socio-cultural and gender factors contributing towards women's poor health status in the management of reproductive health problems.
- To strengthen the clinicians' skills in management of certain reproductive health problems.
- To enhance the clinicians' communication and counselling skills.

OHT-2.1

INDICATORS FOR WOMEN'S HEALTH IN

LIFE STAGES	INDICATORS
• Girl child	• Sex ratio at birth (920)[1] • Sex ratio 0 to 6 years (927) [1] • Vaccinated All (40.9%)[2] None (15.3%)[2] • Vitamin A atleast one dose (28.4%)[2] • Taken to health facility or provider for treatment of diarrhoea (61.9%)[2]
• Adolescent girl	• Undernutrition (45.0%)[2] • Rape victims (29.5%)[2]
• Reproductive Age Span	• Anaemia (52.0%)[2] • Anaemia as indirect cause of death (19.3%)[2] • Deaths due to anaemia (4.7%)[2] • Age at marriage (Median --16.4%)[2] • Age at first birth (Median 19.2)[2] • Maternal Mortality Ratio • Reproductive Tract Infections (indicated by abnormal vaginal discharge 30.1% of currently married women)[2] • Gender based domestic violence -- Beaten by husband (18.8%)[2] • Decision making about their own health care (51.6%)[2]
• Older Women	• Access to money (59.6%)[2] • Undernutrition • Osteoporosis

Sources : 1. National Family Health Survey-Round 2
2. Gopalan and Shiva (2000).

OHT-2.2

SOCIAL DETERMINANTS OF HEALTH

- Women's status in the family and community
- Religion
- Traditions
- Educational status
- Poverty
- Environmental degradation, workload and women's health
- Gender based Violence

Gender and Health

OHT-3.1

SEX AND GENDER

Definitions of Sex and Gender

- Sex refers to the biological differences between men and women.
- Gender refers to roles that men and women play and the relations that arise out of these roles. They are socially constructed, not physically determined.

Characteristics of Gender

- Relational ! Socially Constructed
- Hierarchical ! Power Relations
- Changes ! Changes over time
- Context ! Varies with ethnicity,class, culture, etc.
- Institutional ! Systemic

OHT-3.2

GENDER AS A SYSTEM

Certain beliefs in society about men and women
(eg men are strong, women are weak, men are rational, women are emotional)

↓

Defining different gender norms which govern the behaviour of men and women in society
(eg men can express themselves, men can be articulate, women must not express themselves or be articulate)

↓

Define different gender roles for men and women
(eg men must be breadwinners, women must be carers, nurturers)

↓

Sexual division of labour
Productive for men earning income/wages Reproductive for women caring, nurturing social reproduction. Community leadership for men eg Sarpanch. Informal leadership without public or formal recognition for women (eg. dai, wise woman)

↓

Different activities and tasks for men and women (women's tasks undervalued and invisible, eg cooking, cleaning, women's work fragmented, public domain for men, private for women).

↓

Access to and control over resources
(Resources like money, land, technology, knowledge, self-esteem, time, space).

↓

Decision making and Power

Those who make decisions and have power are the ones who influence social beliefs and gender norms for behaviour, sexual division of labour, and access to and control over resources. Thus, this is a system, which feeds on its subsystems and perpetuates itself. The beauty of the system is that it can be broken anywhere either by changing social beliefs, or by changing norms for behaviour of men and women, or by changing the work that men and women are supposed to do, or in the allocation of resources. Thus it can be said that gender constructs can be changed over time, over space, and over contexts.

OHT-3.3

ORIGIN OF DIFFERENCES IN HEALTH / ILLNESS PROFILES

BIOLOGICAL DIFFERENCES

- Anatomical/Physiological
- Anatomical, Physiological and Genetic susceptibilities
- Anatomical, Physiological and Genetic resistances/immunities
- Immunities

SOCIAL DIFFERENCES

- Roles and responsibilities
- Access and control
- Cultural influences and expectations
- Subjective identity

HEALTH SITUATIONS, CONDITIONS AND / OR PROBLEMS

- Sex Specific
- Higher prevalence in one or other sex
- Different characteristics for men and women
- Generate different response by individuals/family/institutions depending on whether the person is male or female

Source : PAHO (1997)

Scope of Health Post and Dispensary

OHT-4.1

Findings from Baseline Studies

Study	Results
Men's involvement study	• Men had unmet information needs regarding reproductive and sexual health of, both, women and men. • Men prefer men health workers to conduct health information sessions
Communication between clients and providers	• Staff behaviour disrespectful towards clients • Limited counselling, information and education. • Sensitising providers to their behaviour resulted in improvement
Referral study	• Success of referral system depends on implementation of clinical and administrative protocols at all levels of health care delivery system and strong two way feedback system
Review of health care facilities	• One third of the health posts and dispensaries under one roof resulted in duplication of resources • Two third positions of medical officers vacant in one of the wards • Logistics for equipment repairs and facility infrastructure need improvement. • 40 per cent health posts and 50 per cent dispensaries had difficulty to provide confidentiality and privacy
Health Care Providers' perception study	• Limited skills to diagnose and treat reproductive health problems • Need for refresher training

OHT-4.2

WEEKLY PLAN OF ACTIVITIES FOR THE PROPOSED INTEGRATED HEALTH CENTRE

DAY	FACILITY (CENTRE)			OUTREACH	
	TIME	Activity	Person responsible	Activity	Person responsible
MON	AM	GEN. OPD	M.O.I/c., FTMO in absence of M.O.I/c	CLEANSING + FINE Collection (full day)	FTMO
	PM	GEN. OPD FW & COUNSELLING	PHN to coordinate with ANM, FTMO. MO for CuT	Home visits (3 hours) Routine (20 HHs) Goal based (20 HHs) Goal based (20 Hhs)	CHVs ANMs MPWs
TUE	AM	GEN. OPD IMMUNISATION	MO I/c FTMO, PHN, ANM, CHV	HOME VISIT (3 hrs) Routine (20 HHs) Goal based (20 HHs)	CHVs ANMs MPWs
	PM	GEN.OPD, WELL BABY CLINIC, FW	M.O.I/c, FTMO, PHN to coordinate with ANM	Goal based (20 Hhs)	
WED	AM	COUNSELLING GEN. OPD	MO I/c, FTMO	HOME VISIT (3 hrs) Routine (20 HHs) Goal based (20 HHs)	CHVs ANMs MPWs
	PM	GEN.OPD, WELLBABY CLINIC, FW & COUNSELLING	M.O.I/c, FTMO, PHN to coordinate with ANM	Goal based (20 Hhs)	
THU	AM	GEN. OPD	MO I/c, FTMO	IMMUNISATION CAMPS (3 hrs.)	FTMO PHN
	PM	GEN.OPD, FW & COUNSELLING ANC	M.O.I/c, FTMO, PHN to coordinate with ANM	HOME VISIT (3 hrs) Routine (20 HHs) Goal based (20 HHs) Goal based (20 Hhs)	CHVs ANMs MPWs
FRI	AM	GEN. OPD	MO I/c, FTMO	CLEANSING (ADOPTED SLUMS) (3 hrs.)	FTMO, PHN, ANM, HPA, CHVs, ANMs, MPWs
	PM	GEN.OPD, FW & COUNSELLING, ANC, WELL BABY CLINIC,	M.O.I/c, FTMO, PHN to coordinate with ANM	HOME VISIT (3 hrs) Routine (20 HHs) Goal based (20 HHs) Goal based (20 HHs)	
SAT	AM	GEN. OPD	MO I/c, FTMO		FTMO, PHN, ANM, HPA, CHVs, ANMs, MPWs
	PM	REVIEW MEETINGS, CME, RECORDS/ REPORTS	MO I/c, FTMO	IMMUNISATION CAMP (3 hrs.) HOME VISIT (3 hrs) Routine (20 HHs) Goal based (20 HHs)	

Communication

OHT-5.1

To be a good listener

- Be attentive, look at the speaker, take down notes for later reference
- Comprehend what your client is saying
- Absorb clearly. If you listen carefully, you will comprehend and understand what the client is saying and then you will be able to absorb or take it in better. This will help in decision making and taking action
- Listening to the underlying feelings in any message is important

OHT-5.2

Essentials for non-verbal skills

- Be relaxed
- Have an open and approachable posture
- Lean towards client
- Maintain eye contact
- Sit squarely and smile

OHT-

Skills for effective IPC

- Effective listening - leaning forward, eye contact, head nod, responses like" I see", "uh-huh"
- Encourage dialogue - ask open ended questions
- Avoid interruption
- Avoid premature diagnosis - do not jump to conclusions before hearing the person fully
- Probe for more information by asking open ended questions
- Ask the person what seems to have caused the problem, what are the difficulties, any other worries?

OHT-5.4

Essentials for verbal skills

- Make the patient comfortable
- Friendly tone and voice
- Personal touch
- Give complete information
- Invite clarifications

Counselling

OHT-6.1

DEFINITION

Exchange of information as a means of clarifying and resolving problems, enabling the client to make decisions for planned action.

Components Of Counselling

- Establishing rapport
- Obtaining information
- Listening and questioning
- Giving information
- Discussion
- Decision-making

OHT-6.2

ERRORS IN COUNSELLING

- Directing
- Labelling
- Moralising, preaching
- Giving false reassurances
- Denying client's feelings
- Encouraging dependence
- Breaking confidentiality
- Interrogating

OHT-6.3

CLIENT'S RIGHTS

- Accurate information on available skilled care
- Freedom of choice
- Confidentiality and privacy
- Compassion, respect and understanding

OHT-6.4

SKILLS IN COUNSELLING

Macroskills Of Counselling

- Clarification
- Asking open ended question
- Conveying empathy
- Reassurance
- Summarising
- Recap

Microskills Of Counselling

- Paraphrasing of content
- Reflection of feeling
- Appropriate use of silence
- Focussing
- Confrontation

OHT-6.5

QUALITIES AND SKILLS OF A COUNSELLOR

- Skill at reaching out
- Have goodwill and sincere interest in the welfare of others
- Warmth
- Humanness
- Sensitivity to culture
- Willing to communicate care and respect for the person you are trying to help
- Good listening skills
- Able to inspire feelings of trust, credibility and confidence in people
- Self-respect, self-appreciation, self-worth
- Openness to learning and growth
- Willingness to take risks: making mistakes and to admit that one has done so
- Knowledgeable about areas that are of value to the client
- Willingness to serve as a model for others
- Efficient perception of reality
- Able to understand the behaviour of others without imposing value judgements
- Able to identify self-defeating behaviour patterns and help client change these to more rewarding behaviour patterns
- Able to reason systematically

Menstrual Problems

OHT-7.1

MENSTRUAL PROBLEMS

- Physiology of Menstruation
- Women's perceptions of Menstruation
- Gender issues in Menstruation

OHT-7.2

CLINICIAN'S ROLE

- History taking
- Examination, investigations, management
- Information and counselling
- Referral

OHT-7.3

TYPES OF MENSTRUAL PROBLEMS

- Amenorrhoea (Primary and Secondary)
- Oligomenorrhoea
- Hypomenorrhoea
- Polymenorrhoea
- Menorrhogia
- Metrorrhagia
- Menometrorrhagia
- Mid Month Staining
- Premenstrual Staining & Syndrome
- Dysmenorrhoea

Pregnancy and Antenatal Care

OHT-8.1

PREGNANCY

Signs and symptoms of Pregnancy

- Amenorrhoea
- Nausea or sickness
- Bladder symptoms
- Breast changes
- Uterine changes
- Awareness of foetal movement
- Palpable uterine contractions

OHT-8.2

DIAGNOSING PREGNANACY

- Using an Immunological Test for
- Using a Pregnancy Colour Kit
- Sonography

OHT-8.3

ANTENATAL CARE

- Objectives of ANC
- Procedures to be followed during the visits
- ANC advice

OHT-8.4

COMMON COMPLAINTS

- Morning sickness
- Constipation
- Heartburn
- Haemorrhoids / Varicose Veins
- Vaginal Discharge

OHT-8.5

Physical Effects of Violence during Pregnancy

- Insufficient weight gain
- Vaginal/Cervical/Kidney infections
- Vaginal Bleeding
- Abdominal Trauma
- Haemorrhage
- Exacerbation of chronic illnesses
- Complications during labour
- Delayed prenatal care
- Miscarriage
- Low birth weight
- Ruptured membranes
- Abruption placenta
- Uterine infection
- Foetal bruising, fractures and haematomas
- Death

OHT-8.6

RISK FACTORS

- More than 35 years old.
- Height less than four and a half feet.
- Parity more than five.
- History of two or more abortions.
- Blood pressure more than 130/90 mm of mercury.
- Haemoglobin less than 10 gm per cent.
- Diabetes.
- Cardiac disease.
- History of bleeding during pregnancy.
- History of leaking per vagina.
- Multiple pregnancies.
- Polyhydramnious.
- Intrauterine growth retardation.
- Post maturity

Leucorrhoea, Sexually Transmitted Diseases

OHT-9.1

DEFINITIONS

- Definition of leucorrhoea
- Normal vaginal secretions
- Pathological leucorrhoea
- Women's perceptions
- Gender issues

OHT-9.2

CLINICIAN'S ROLE

- History taking
- Examination, investigations and management
- Information and counselling
- Referral

OHT-9.3

TYPES OF INFECTIONS

- Candida albicans
- Gardnerella vaginalis
- Trichomonas vaginalis
- (Signs and symptoms, Investigations, Treatment)

OHT-9.4

VAGINAL DISCHARGE IN ADOLESCENT GIRLS

- Symptoms
  - Thin, watery or a thin, watery discharge with a fishy odour
  - Thick curd like discharge
- Investigation
  - Haemoglobin levels,
  - Urine and stool examinations
- Management
  - Reassurance
  - Dietary advice
  - Advice on personal hygiene.

OHT-9.5

TYPES OF RTIs

- Endogenous
- Infective
- Iatrogenic

OHT-9.6

FACTORS CONTRIBUTING TO THE STI PROBLEM

- Many STIs are asymptomatic
- Lack of health seeking behaviour
- Failure to treat patients effectively
- Failure to treat partners
- Failure to promote preventive measures

OHT-9.7

SOCIAL FACTORS AFFECTING STIs

- Urbanisation and industrialisation
- Migration
- Social disruption
- Work related migration and travel
- Socio-economic problems and lack of economic opportunities
- Changing societal values
- Alcoholism and other drug abuses

OHT-9.8

COUNSELLING

- Take full prescribed course of treatment for cure
- Avoid sex till cured so that infection is not transmitted to others
- Use condoms to avoid spreading of infection
- Have only one sexual partner
- Come regularly for follow up visits
- Bring sexual partners for examination and treatment
- Protect your baby by reporting pregnancy and taking full treatment

Childlessness

OHT-10.1

Definition

Childlessness means the inability to conceive after one year of sexual life without the use of contraceptives.

Types of Childlessness

- Primary childlessness
- Secondary childlessness

Pathological Childlessness

- In 25% of the cases, the defect with the male.
- In 50 % of the cases, female factors.
- In 25 % of the cases, both factors.
- In 10% of the cases unexplained childlessness.

OHT-10.2

Causes of Childlessness

Male Factors	Female Factors
Systemic Factors	Systemic Factors
Psychological Factors	Psychological Factors
Endocrinopathy	Endocrinopathy
Immunologic	Immunologic
Coital difficulties	
Genital Factors	Genital Factors

OHT-10.3

Investigations

Primary Level (Health Post / Dispensary)

- Clinical Evaluation of Woman
- Clinical Evaluation of Husband

Semen analysis

Secondary level

Investigations in women

Routine laboratory investigations

- Cervical Dilatation and curettage (D & C)
- Hysterosalpingograph
- Ovulation tests
- Tests for Cervical Factors

Tertiary level (Teaching Hospital)

- Specialised investigation

OHT-10.4

Management

Special Treatment

- Artificial insemination
- Invitrofertilisation and embryo transfer (IVF)
- Gamete intrafallopian transfer (GIFT)
- Adoption

OHT-10.5

Social Implications of Childlessness

Men feel		Women feel
• Careless	!	Helpless
• Hesitant	!	Threatened
• Aggressive	!	Self-pity

OHT-10.6

Health Worker's Role

- Emotional support
- Appropriate referral
- Motivate to complete the treatment
- Advice on adoption

Consultation Process and Communication with Women

OHT-11.1

Steps in Consultation

- History Taking

  General Guidelines

  - Need for privacy
  - Establishing rapport
  - Time and patience
  - Types of questions
  - Use of local terminology
  - Onset of the problem
  - Believing in women

OHT-11.2

Various Aspects of a Woman's History

- Obstetric history
- General history
- Gynaec history
- Menstrual history
- Sexual history

OHT-11.3

- **Examination**
  - Examination of breasts
  - Abdominal examination
  - Examination of vulva
  - Internal examination

OHT-11.4

- Investigation
- Management
- Reassurance
- Motivation
- Information
- Follow up
- Referral

Annexures

Annexure 1

TASK ANALYSIS

SUBJECT: To provide guidance and counselling for childlessness patients

ACTIVITY	KNOWLEDGE	ATTITUDE	SKILL
History taking	• What is childlessness • What are the types of childlessness • What are the causes of childlessness	• Being sensitive to the patient's concern for inability to conceive • Have a gender perspective on the condition • Understanding that a woman will or may take time to understand questions and answers • Understanding that a woman or a man finds it difficult to talk on such subjects • Listening patiently to the patient's problems • Understanding the patient's need for privacy/confidentiality • Understanding the socio-cultural environment of the patient	• Ability to question and probe so as to elicit important information • Ability to listen • Ability to record the history completely
Examination	• What examination is required • Examination of women • General examination • Systemic examination • Vaginal examination • Per Speculum Examination • Bimanual pelvic examination • Examination of husband • General examination • Systemic examination • Examination of genitals	• Understanding that a patient needs privacy • Understanding that a patient needs to know what examination is going to be done • Understanding a woman's fears about examination, especially internal examination • Understanding that a patient needs time to prepare herself/himself for examination	• Ability to make the patient feel comfortable during examination • Ability to examine the patient and reach a diagnosis • Ability to record the examination findings completely

ACTIVITY	KNOWLEDGE	ATTITUDE	SKILL
Investigation	• What investigations are required • Where to refer for investigations • How to interpret the report	• Understanding that the couple needs to know why the investigations are required and how they will be done • The couple needs to know the results of the investigations	• Ability to assess what investigations are required • Ability to record the investigations required on the case paper/referral slip • Ability to motivate the patient for an investigation, especially the man • Ability to interpret the investigation reports
Management	• What is the diagnosis • What is the treatment • What can be managed at the Health Post/Dispensary level • Where to refer the couple for treatment if it cannot be managed at the facility	• Understanding the barriers to seeking and completing treatment	• Ability to motivate the patient to take the full course of prescribed treatment • Ability to manage adverse reactions
Information and counseling	• Principles of the two-way communication process • Counselling process • Causes of childlessness • Sexuality • Investigations • Treatment • Other alternatives to treatment • The implications of the investigation and treatment in terms of cost, time and outcome	• Respecting a woman's belief system (faith, indigenous methods) • Understanding the patient's need for privacy and confidentiality • Understanding the need to sensitise the family members towards the problem • A woman needs reassurance from the clinician that she will be okay and care will be taken to minimise the problem • Understanding of the male psyche	• Ability to answer the couple's queries • Ability to handle questions related to sexuality comfortably • Ability to explain the cause of childlessness • Ability to motivate the husband to undergo examination, investigation, and treatment • Ability to reassure the woman and the man • Ability to give relevant information

ACTIVITY	KNOWLEDGE	ATTITUDE	SKILL
	• The need for active involvement of both the husband and the wife in the treatment process		
Follow up visits	• When is the follow up required • What should be done during follow up visits • When to refer	• Understanding why a patient does not come for follow up visits • Understanding the patient's inability to follow the doctor's advice	• Ability to motivate the patient to come for follow up visits • Ability to do timely referrals • Ability to help the patient seek solutions to her problems
Referral	• Referral Centres for investigations and treatment • Timing of Referral Centres • Location of the Referral Centre and how it can be reached and at what cost • What procedure is to followed at Referral Centre • Adoption centres and procedure for adoption • Counselling centres for sexual problems • Referral centres for other alternatives to treatment	• Being sensitive to the financial constraints • Understanding barriers to seeking treatment	• Ability to motivate the couple to seek treatment from the Referral Centre • Ability to motivate the couple to adopt a child if the couple is unable to conceive for a long time

SUBJECT: Management of patients with menstrual problems

ACTIVITY	KNOWLEDGE	ATTITUDE	SKILL
History taking	• Physiology of menstruation • Various types of menstrual problems • What are the causes of these problems • What is the clinical presentation of each of these problems • Differentiation between physiological and pathological problems • Understanding the patient's language and different terminology used	• Understanding the patient's need for privacy • Understanding that a woman will or may take time to understand questions and answers • Having patience to listen to the patient's problems • Understanding the barriers to seeking treatment • Appreciation of gender dimensions of STIs	• Ability to question and probe so as to elicit important information • Ability to listen • Ability to record the history completely • Ability to communicate using local terminology
Examination	• What examination is required • General examination • Systemic examination • Vaginal examination • Per speculum examination • Bimanual pelvic examination	• Understanding that a patient needs privacy • Understanding the patient's need to know what examination is going to be done • Understanding a woman's fear about examination • Understanding that a patient needs time to prepare herself for the examination	• Ability to make the patient feel comfortable during examination • Ability to examine the patient and to reach a diagnosis • Ability to record the examination findings completely
Investigation	• What investigations are required • Where to refer for investigations • How to interpret the report	• Understanding that the patient needs to know why the investigations are required and how they will be done • Understanding a woman's fear about investigations	• Ability to assess what investigations are required • Ability to record the investigations required on the case paper/referral slip • Ability to motivate the patient for investigations

ACTIVITY	KNOWLEDGE	ATTITUDE	SKILL
			• Ability to interpret the investigation reports • Ability to explain to the patient why investigations are required • Ability to explain the results to the patient in a simple language that she is able to understand
Management	• What is the diagnosis • What is the treatment • What can be managed at Health Post /Dispensary level • Where to refer a patient for treatment if it cannot be managed at the facility	• Understanding barriers to seeking and completing treatment	• Ability to motivate the patient to take the full course of prescribed treatment • Ability to manage adverse reactions
Information and counselling	• Principles of two-way communication • Counselling process • Physiology of menstruation • Knowledge about causes of menstrual problems, investigations and treatment • Beliefs associated with menstruation • The implications of the examination in terms of cost, time and outcome • The implications of the investigation in terms of cost, time and outcome	• Understanding the patient's need for privacy and confidentiality • Understanding the woman's need for information • Understanding that a woman has questions • Believing that a woman has the ability to understand • Understanding the woman's concern about menstrual problems • A woman needs reassurance from the	• Ability to answer the questions asked by the woman • Ability to motivate the patient to follow the advice given by the doctor • Ability to clear the myths and misconceptions associated with menstruation • Ability to reassure a woman • Ability to give relevant information

ACTIVITY	KNOWLEDGE	ATTITUDE	SKILL
	• The implications of the treatment in terms of cost, time and outcome • The need for active involvement of the patient in the treatment process	clinician that she will be okay and care will be taken to minimise the problem	
Follow up visits	• When is the follow up required • What should be done during follow up visits • When to refer	• Understanding why a woman does not come for follow up visits • Understanding the woman's inability to follow the doctor's advice	• Ability to motivate the patient to come for follow up visits • Ability to do timely referrals • Ability to help the woman seek solutions to her problems
Referral	• Referral centers for investigations and treatment • Timing of referral centres • Location of the Referral Centre, how it can be reached, and what cost • What procedure is to followed at the Referral Centre •	• Being sensitive to financial constraints • Understanding barriers to seeking treatment •	• Ability to do timely referrals • Ability to motivate the patient to seek services at the referral centres • Ability to fill in the referral slip completely •

SUBJECT: Management of patients with Leucorrhoea / RTI / STI

ACTIVITY	KNOWLEDGE	ATTITUDE	SKILL
History taking	• What is leucorrhoea / RTI / STI • Various organisms causing leucorrhoea / RTI / STI • What is the clinical presentation of each of these problems • Differentiation between physiological and pathological problems • Understanding the patient's language and different terminology used for leucorrhoea / RTI / STI	• Understanding the patient's need for privacy • Understanding that a woman will or may take time to understand questions and answering • Having patience to listen to the patient's problems • Understanding the barriers to seeking early treatment • Showing respect for the patient's understanding of the body	• Ability to question and probe so as to elicit important information • Ability to listen • Ability to record the history completely • Ability to communicate using local terminology
Examination	• What examination is required • General examination • Systemic examination • Vaginal examination • Per speculum examination • Bimanual pelvic examination	• Understanding the patient's need for privacy • Understanding that a patient needs information on what examination is going to be done • Understanding the woman's fear about examination, especially internal examination • Understanding that a patient needs time to prepare herself for the examination	• Ability to make the patient feel comfortable during examination • Ability to examine the patient and to reach a diagnosis • Ability to record the examination findings completely
Investigation	• What investigations are required • How to collect specimen for investigation	• Understanding that the patient needs to know why the investigations are required and how they will be done	• Ability to assess what investigations are required

ACTIVITY	KNOWLEDGE	ATTITUDE	SKILL
	and examination • How to collect specimen for investigation and send it for laboratory investigation • Where to refer for investigations • How to interpret the laboratory report	• Understanding a woman's fear about investigations • The patient needs to know the result of the investigations	• Ability to record the investigations required on the case paper/referral slip • Ability to motivate the patient for investigation • Ability to collect specimen, prepare a wet mount and examine for a diagnosis • Ability to collect and send the specimen in an appropriate manner • Ability to interpret the investigation report • Ability to explain to the patient why investigations are required • Ability to explain the results to the patient in a simple language that the patient is able to understand
Management	• What is the diagnosis • What is the treatment • What can be managed at the Health Post/Dispensary level • Where should the patient be referred if it cannot be managed at the facility	• Understanding barriers to seeking and completing treatment	• Ability to motivate the patient to take the full course of the prescribed treatment • Ability to manage adverse reactions
Information and counselling	• Principles of the two-way communication process • Counselling process • Knowledge about causes of leucorrhoea /	• Understanding the patient's need for privacy and confidentiality • Understanding a woman's need for information	• Ability to motivate the woman to bring her partner for examination • Ability to motivate the partner for examination, investigation and treatment

ACTIVITY	KNOWLEDGE	ATTITUDE	SKILL
	RTI / STI, investigations, treatment • The need for partner involvement in treatment of sexually transmitted infections • Beliefs associated with leucorrhoea • The implications of the examination in terms of cost, time and outcome • The implications of the investigation in terms of cost, time and outcome • The implications of the treatment in terms of cost, time and outcome • The need for active involvement of the patient in the treatment process	• Understanding that a woman will have questions • Believing that a woman has the ability to understand • A woman needs reassurance from the clinician that she will be okay and care will be taken to minimise the problem	• Ability to motivate the patient to follow the advice given by the doctor • Ability to address beliefs associated with leucorrhoea • Ability to answer the woman's questions/doubts/concerns • Ability to reassure the woman • Ability to give relevant information
Follow up visits	• When is the follow up required • What should be done during follow up visits • When to refer	• Understanding why a woman does not come for follow up visits • Understanding the woman's inability to follow the doctor's advice	• Ability to motivate the patient to come for follow up visits • Ability to do timely referrals • Ability to help the woman seek solutions for her problems
Referral	• When to refer • Referral Centres for investigations and treatment • Timing of the Referral Centre • Location of the Referral Centre, how it can be reached and at what cost • What procedure is followed at the Referral Centre	• Being sensitive to the patient's financial constraints • Understanding barriers to seeking treatment by a woman	• Ability to do timely referrals • Ability to motivate the patient to seek services from the referral centres • Ability to fill in the referral slip completely • Ability to motivate the woman to give feedback after referral

SUBJECT: Management of pregnant women

ACTIVITY	KNOWLEDGE	ATTITUDE	SKILL
History taking	• Physiology of pregnancy • High risk factors including GBV • Importance of last menstrual period • Importance of past obstetrics history • Diagnosis of pregnancy	• Understanding various socio-cultural factors affecting pregnancy • Understanding that a woman will or may take time to understand questions and answer	• Ability to question and probe so as to elicit important information • Ability to listen • Ability to record the history completely • Ability to detect high risk cases
Examination	• What examination is required • General examination • Systemic examination • Vaginal examination	• Understanding a woman's need for privacy • Understanding a woman's need to know what examination is going to be done • Understanding a woman's fear about examination • Understanding that the patient needs time to prepare herself for the examination	• Ability to make the patient feel comfortable during examination • Ability to record the examination findings completely • Ability to detect high risk cases
Investigation	• What investigations are required • How to collect blood and urine samples for investigation and examination • How to collect blood and urine samples and send it for laboratory investigation • Where to refer for investigations	• Understanding a woman's need to be told why the investigations are required and how they will be done • Understanding a woman's fear about investigations	• Ability to assess what investigations are required • Ability to record the investigations required on the case paper/referral slip • Ability to motivate the patient for investigations • Ability to collect blood and urine sample and examine (Hb and urine examination) • Ability to collect blood and urine sample and send for investigations in an appropriate manner

ACTIVITY	KNOWLEDGE	ATTITUDE	SKILL
			• Ability to explain to the patient why investigations are required • Ability to explain the results to the patient in a simple language that the patient is able to understand
Management	• Importance of taking iron folic acid, calcium and tetanus toxoid • Treatment of any complications in pregnancy	• Understanding barriers to seeking and completing treatment	• Ability to motivate the patient to take the full course of the prescribed treatment • Ability to manage adverse reactions
Information and counselling	• Principles of the two-way communication • Counselling process • Physiology of pregnancy • Care during pregnancy • Warning signs for patient to seek immediate medical attention • Process of child birth • Care during lactation • Care of newborn • The implications of the investigation in terms of cost, time and outcome • The implications of the treatment in terms of cost, time and outcome • The need for active involvement of the patient in the treatment process	• Understanding the role of other family members and the need to involve them, especially the husband • Understanding that a woman need information • Understanding that a woman has questions • Believing that a woman has the ability to understand • Understanding the anxieties/ curiosities about the first pregnancy • A woman needs assurance from the clinician that she will be okay and care will be taken to minimise the problem	• Ability to motivate the woman to bring her husband / other family members for counselling and advice on care to be taken during the pregnancy • Ability to motivate the patient to follow the advice given by the doctor • Ability to answer the woman's questions /doubts / concerns • Ability to reassure the woman • Ability to give relevant information

ACTIVITY	KNOWLEDGE	ATTITUDE	SKILL
Follow up visits	• When is the follow up required • What should be done during follow up visits • When to refer	• Understanding why a woman does not come for follow up visits • Understanding the woman's inability to follow doctors advice	• Ability to motivate the woman to come for follow up visits • Ability to do timely referrals • Ability to help the woman seek solutions to her problems
Referral	• When to refer • Referral centres for investigations and treatment • Timing of the Referral Centre • Location of the Referral Centre, how to reach it and the costs incurred • What procedure is followed at the Referral Centre	• Being sensitive to financial constraints • Understanding barriers to seeking treatment	• Ability to do timely referrals • Ability to motivate the patient to seek services from Referral Centres • Ability to fill in the referral slip completely

EVALUATION TOOLS

GUIDELINES FOR FIELD TRAINING

Trainees/Trainers

Having received a refresher course in selected aspects of gynecology and obstetrics in a classroom situation, field training is required to enable the doctors to take care of women with certain reproductive health problems at their health care facilities. A checklist ensures that there is maximum utilisation of field training. At the end of each day, the trainee doctors should tick the cases they have seen in the checklist. This will help them to ensure that all aspects required for the management of the patients are adequately covered.

Gynaecology checklist

- How to do history taking for a patient with gynaecological problems (menstrual problems, reproductive tract infections, and childlessness).
- How to conduct an examination in a patient with gynaec problem:
  - Examination of vulva
  - Vaginal examination
  - Per speculum examination
  - Bimanual pelvic examination
  - Per abdominal examination
  - Breast examination
- How to collect a sample of the vaginal discharge.
- How to transport the sample of vaginal discharge.
- How to do a wet mount microscopy.
- How to take a Pap smear.
- How to transport the Pap smear sample.
- How to interpret investigation reports of vaginal discharge and Pap smear.
- How to manage a patient with menstrual problems, reproductive tract infections and infertility.
- How to impart information and counsel a patient with menstrual problems, reproductive tract infections, and infertility.

Obstetrics checklist

- How to do history taking in a woman registered for antenatal care.
- How to examine a pregnant woman.
- How to detect high-risk pregnancies.
- How to manage a pregnant woman.
- How to impart information and counsel a pregnant woman.

Annexure 2.2

CHECKLIST FOR PARTICIPANTS FOR FIELD TRAINING

This checklist has been provided to ensure that all aspects are covered related to the management of gynaec problems and antenatal patients during the field training.

It is expected that every trainee will handle at least 10 cases each of RTIs, menstrual problems, childlessness and women registered for antenatal care. Write in each column how many gynaecological or antenatal patients a trainee has managed to handle. How many wet mount or Pap smears were done by the trainee daily.

At the end of each day

- write in a notebook about the cases managed in the OPD
- What the trainee has learnt each day.

ACTIVITY	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
Menstrual Problems • History taking • Examination • Management • Information & Counselling **Reproductive Tract Infections** • History taking • Examination • Management • Information & Counselling **Childlessness** • History taking • Examination • Management • Information & Counselling **Antenatal Care** • History taking • Examination • Management • Information & Counselling **Wet Mount** **Pap Smear**					

Name of participant:

Name of facility where training was received:

Date:

OBSERVATION CHECKLIST MENSTRUAL PROBLEMS

HISTORY TAKING	YES	NO	NR
Did the clinician ask the following questions ?			
Age			
Marital status			
Occupation			
Onset, duration and progress of			
Present complaints			
Present menstrual history			
○ number of days			
○ regularity of cycle			
○ volume of blood loss			
○ passing of blood clots			
○ LMP			
○ pain during menstruation			
Past menstrual history			
○ number of days			
○ regularity of cycle			
○ volume of blood loss			
Any other associated problems			
Obstetric history			
History of using contraceptives			
History of abortion / MTP			
Past history of major illness			
Emotional stress / psychological disturbances			

EXAMINATION	YES	NO	NR
Did the clinician conduct the following examinations?			
General examination			
Systemic examination			
Breast examination			
Per abdominal examination			
Vaginal examination			
Per speculum examination			
Bimanual pelvic examination			

INVESTIGATION	YES	NO	NR
Did the clinician ask for the following investigations?			
Hb			
Sonography			
Hormonal assays			

MANAGEMENT	YES	NO	NR
Did the clinician			
Explain to the patient the probable cause of the problem			
Prescribe the correct drugs in the correct dosage			
Explain to the patient how to take the drugs			
Tell the patient that she has to participate actively in the treatment process by taking the drugs regularly and follow up visits			
Explain to the patient what advise need to be followed (diet, exercise,hot water formentation etc.)			
Tell the patient that she has to participate actively in the treatment process by following the advise given			

REFERRAL		YES	NONR
While referring the patient did the Clinician			
Tell the patient which referral centre to visit			
Ensure that the patient knows how to reach the referral centre			
Tell time & cost that will be incurred in to reach the centre			
Tell the patient what time to visit the referral centre			
Tell the patient which department to visit			
Ensure patient's convenience for going to the referral centre			
Suggest an alternative centre if this is inconvenient			

DURING FOLLOW UP VISITS	YES	NO	NR
Did the clinician			
Enquire for patient's inability to come regularly for follow up visits (in case a patient has come late)			
Enquire whether symptoms were improving			
Enquire whether the treatment was being taken			
Enquire whether there were any problems in following the treatment			
Attempt to help the women to overcome the problems in following treatment or advise			
Enquire for any other complaints			
Inform the patient when to come for further follow up visits			
Refer the patient if required			
Help the patient to solve her problems regarding followup visits			

INFORMATION	YES	NO	NR
Did the Clinician			
Give information on physiology of menstruation			
Make use of the visual aids			

OBSERVATION CHECKLIST LEUCORRHOEA

HISTORY TAKING	YES	NO	NR
Did the clinician ask the following questions ?			
Age			
Marital status			
Occupation			
Onset of present complaints (since how long)			
Colour of discharge			
Type of discharge			
Blood stained discharge			
Quantity of discharge			
Smell of discharge			
Itching associated with discharge			
Timing of discharge related to menstrual period			
Any other complaints			
Menstrual history			
Obstetric history			
Past history of tuberculosis/anaemia/dysentry/diabetes or any other major illness			
History of using contraceptives			
History of taking antibiotics previously			
Emotional stress			

EXAMINATION	YES	NO	NR
Did the clinician conduct the following examinations?			
General examination			
Systemic examination			
Per abdominal examination			
Examination of vulva			
Vaginal examination			
Per speculum examination			
Bimanual pelvic examination			

INVESTIGATION	YES	NO	NR
Did the clinician ask for following investigations ?			
Hb			
Urine examination			
Stool examination			
Microbiological examination of white discharge			
Did the clinician			
Explain to the patient what investigations are required and why they are required in a simple language			
Explain to the patient in a simple language how the investigations would be done			

Assess correctly what investigations are required			
Motivate the patient for investigation			
Collect the specimen for investigation			
Examine the specimen (wet mount)			
Send the specimen in an appropriate manner to the laboratory			
Record the investigations required on the case paper / referral slip			
Interpret the investigation report correctly			
Explain to the patient the investigation reports in a simple language			

MANAGEMENT	**YES**	**NO**	**NR**
Did the clinician			
Explain to the patient the probable cause of the problem			
Prescribe the correct drugs in the correct dosage			
Explain the patient how to take the drugs			
Tell the patient that she has to participate actively in the treatment process by taking the drugs regularly and follow up visits			

REFERRAL	**YES**	**NO**	**NR**
While referring the patient did the Clinician			
Tell the patient which referral centre to visit			
Tell the patient how to go to the referral centre			
Tell the time and cost that will be incurred in reaching the referral centre			
Tell the patient what time to visit the referral centre			
Tell the patient which department to visit			
Ensure patients convenience for going to the referral centre			
Suggest an alternative referral centre in case of inconvenience to the patient			
Fill in the referral slip completely			

During follow up visits	**YES**	**NO**	**NR**
Did the clinician			
Enquire for patients inability to come regularly for follow up visits (in case a patient has come late)			
Enquire whether symptoms were improving			
Enquire whether the treatment was being taken			
Enquire whether there were any problems in following the treatment			
Attempt to help the women to overcome the problems in following treatment or preventive measures			
Enquire for any other complaints			
Inform the patient when to come for further follow up visits			
Refer the patient if required			
Help the patient to solve her problems regarding follow up visits			

OBSERVATION CHECKLIST ANTENATAL CARE

HISTORY TAKING	YES	NO	NR
Did the clinician ask the following questions?			
Age			
Marital status			
Duration of marriage			
Occupation of woman			
Occupation of husband			
Monthly income			
Any complaints			
History of tobacco, alcohol consumption			
Menstrual history			
Last menstrual period			
Calculated EDD			
Obstetric history			
Emotional stress			
History of violence			
Past history of tuberculosis/hypertension/diabetes or any other major illness			
Past history of any operation			
History of using contraceptives			
Any other complaints			

EXAMINATION	YES	NO	NR
Did the clinician conduct the following examinations?			
General examination			
Height			
Weight			
Pulse			
Blood pressure			
Pallor			
Jaundice			
Oedema feet			
Systemic examination			
Breast examination			
Abdominal examination			
○ fundal height			
○ position of foetus			
○ foetal heart sounds			
Vaginal examination			
○ speculum examination			
○ bimanual pelvic examination			

INVEST IGATION	YES	NO	NR
Did the clinician ask for the following investigations?			
Blood Test			
Hb			
VDRL			
Blood group			
Urine Test			
Proteins			
Sugar			
Sonography			
Did the clinician			
Explain to the patient what investigations are required and why			
Explain to the patient in a simple language how the investigations would be done			
Assess correctly what investigations are required			
Motivate the patient for investigation			
Examine the specimen (urine for proteins & sugar)			
Record the investigations required on the case paper			
Interpret the investigation report correctly			
Explain to the patient the investigation reports in a simple language			

MANAGEMENT	YES	NO	NR
Did the clinician			
Prescribe the correct drugs in the correct dosage (iron folic acid and calcium)			
Explain to the patient how to take the drugs			
Prescribe tetanus toxoid injection			
Tell the patient that she has to participate actively in the treatment process by taking the drugs and coming for follow up visits regularly			
Ensure whether the patient understood how to take the drugs			
Explain to the patient the probable cause of the problem if any (eg oedema feet, hypertension, etc.)			
Ask the patient to bring her partner if needed			
Explain to the patient what advice needs to be followed			
Tell the patient that she has to participate actively in the treatment process by following the advice			
Ensure that the patient understood the advice to be followed			
Reassure the patient that she can have a normal pregnancy by following the advice			
Ask the patient whether she would face any problems in following the treatment / other measures advised (cost, allergy, inconvenience, perceived side effects)			
Attempt to solve the patient's problem in following the treatment / advice			
Inform the patient when to come for the follow up visit			

	YES	NO	NR
Did the clinician discuss the following aspects of information with the patient?			
First visit			
Physiology of pregnancy			
Diet during pregnancy			
Rest and sleep			
Travel			
Hygiene			
Coitus			
Exercise			
Danger signs to seek immediate attention			

REFERRAL	YES	NO	NR
While referring the patient did the clinician			
Tell the patient which referral center to visit			
Tell the patient how to go to the referral center			
Tell the time and cost that will be incurred in reaching the referral center			
Tell the patient what time to visit the referral center			
Tell the patient which department to visit			
Ensure the patient's convenience for going to the referral center			
Suggest an alternative referral center in case of inconvenience to the patient			
Fill in the referral slip completely			

FOLLOW UP VISITS	YES	NO	NR
During follow up visits did the clinician			
Inquire about patient's inability to come regularly for follow up visits (in case a patient has come late)			
Inquire for any complaints			
Inquire whether the treatment / advice was being followed			
Inquire whether there were any problems in following the treatment / advice			
Attempt to help the women to overcome the problems in following treatment or advice			
Ensure that required doses of Inj. TT have been taken			

	YES	NO	NR
Did the clinician conduct the following examinations?			
Weight			
Blood pressure			
Pallor			
Oedema feet			
Systemic examination			
Fundal height			
Position of fetus			
Foetal heart sounds			

	YES	NO	NR
Did the clinician conduct the following investigations			
Urine test for proteins			
Urine test for sugar			
Inform the patient when to come for further follow up visits			
Refer the patient if required			
Help the patient to solve her problems regarding follow up visits			

	YES	NO	NR
Did the clinician discuss the following aspects during subsequent visits			
Danger signs to seek immediate attention			
Process of child birth			
Breast feeding			
Care of newborn			
Immunization of newborn			

	YES	NO	NR
Did the clinician			
Make the session interactive			

OBSERVATION CHECKLIST CHILDLESSNESS

HISTORY TAKING	YES	NO	NR
Did the clinician ask the following questions			
Age			
Duration of marriage			
Whether husband living with her (since when)			
Occupation			
Occupation of husband			
Monthly income			
Present menstrual history			
o no. of days of bleeding			
o regularity of menstrual cycle			
o blood loss			
o LMP			
o pain during menses			
Past menstrual cycle history			
o no. of days			
o regularity of cycle			
o blood loss			
Whether she had conceived any time			
History of abortions/MTP			
History of using contraceptives			
Past history of tuberculosis /STDs/ diabetes			
History of any major operation			
Sexual history			
o timing of sexual intercourse in relation to menstrual cycle			
o frequency of sexual intercourse			
o pain during coitus			
o any other problems			
Any emotional stress (abuse by family members)			
Any treatment or investigations done			

	YES	NO	NR
Did the clinician			
Explain to the woman the probable causes of childlessness			
Ask the woman to bring her husband for examination			
Did the clinician			
Explain to the husband the probable causes of childlessness			
Motivate the husband to undergo examination and investigations first			

	YES	NO	NR
Did the clinician ask the husband his			
Age			
Occupation			
Addictions (smoking, alcohol, tobacco or any other drug abuse)			
Any problems during sexual intercourse			
Marital status (first or second marriage)			
Any children from previous marriage/relationships			
History of other sexual relationships			
Past history of tuberculosis/diabetes/mumps/STD or any other major illness			
Emotional stress			

EXAMINATION		YES	NONR
Did the clinician conduct the following examinations on the woman's husband?			
General examination			
Systemic examination			
Genital examination			

	YES	NO	NR
Did the clinician conduct the following examinations on the woman?			
General examination			
Systemic examination			
Per abdominal examination			
Vaginal examination			
Per speculum examination			
Bimanual pelvic examination			

INVESTIGATION	YES	NO	NR
Did the clinician ask for the following investigations?			
Husband			
Hb			
Blood group			
VDRL			
Post prandial blood sugar			
Urine test			
Semen analysis			

	YES	NO	NR
Woman			
Hb			
Blood group			
VDRL			
Post prandial blood sugar			
Urine test			
Assess correctly what investigations are required			
Record the investigations required on the case paper / referral slip			
Interpret the investigation report correctly			

MANAGEMENT	YES	NO	NR
Did the clinician			
Prescribe the correct drugs in the correct dosage			
Explain to the patient how to take the drugs			
Tell the patient that she/he has to participate actively in the treatment process by taking the drugs regularly and follow up visits			
Ensure whether the patient understood how to take the drugs			
Explain to the patient what behavioural changes are needed (sexual, addictions)			
Tell the patient that she/he has to participate actively in the treatment process by following the advice given			
Ensure whether the patient has understood the advice to be followed			
Reassure the patient that she may be able to conceive and should not lose hope			
Explain to the patient that treatment of childlessness takes a long time and the importance of continuing the treatment from the same clinician			
Ask the patient whether she/he would face any problems in following the treatment / advise given (cost, allergy, inconvenience, perceived side effects, socio-cultural problems)			

REFERRAL		YES	NONR
While referring the patient did the clinician			
Tell the patient which referral centre to visit			
Tell the patient how to go to the referral centre			
Tell the time and cost that will have to be incurred in reaching the referral centre			
Tell the patient what time to visit the referral centre			
Tell the patient which department to visit			
Ensure patient's convenience for going to the referral centre			
Suggest an alternative referral centre in case of inconvenience to the patient			
Fill in the referral slip completely			

	YES	NO	NR
During follow up visits did the clinician			
Inquire about the patient's inability to come regularly for follow up visits (in case a patient has come late)			
Inquire whether the treatment was being taken /advise being followed			
Inquire whether there were any problems in following the treatment / advise			
Attempt to help the woman to overcome the problems in following treatment or advise			
Inquire about any other complaints			
Inform the patient when to come for further follow up visits			
Refer the patient if required			
Help the patient to solve her problems regarding follow up visits			

PRE TEST / POST TEST

An exhaustive list of questions is provided on the topics covered in this Manual. Trainers are advised to select questions and create their own test. The correct answers and a scoring system is also provided.

1. What are the criteria of normal pregnancy ?

Maximum marks - 5

Answer

Delivery of a single baby in a good condition between 38-42 weeks by dates, with foetal weight of 2.5 kg or more and with no maternal complications.

I2. What are the causes of oedema of the feet in pregnancy?

Maximum marks - 3

Answer

- Physiological
- Preecampsia
- Anaemia
- Hypo proteinaemia
- Cardiac failure
- Nephrotic syndrome

3. What are the risk factors for which the woman needs to be referred to a specialist in obstetrics and gynaecology ? List at least five risk factors.

Maximum marks - 5

Answer

- Age more than 35 yrs.
- Height < 4 1/2 Ft.
- Parity more than 5
- History of 2 or more abortions
- Blood pressure > 130/90 mm of Hg
- Hb < 10 gms %
- Diabetes
- Cardiac diseases
- History of bleeding during pregnancy
- History of leaking per vagina
- Multiple pregnances
- Polyhydramniosis
- IUGR

4. On abdominal examination, the fundus is palpable at the level of navel. What is the gestation period ?

Maximum marks - 1

Answer

- 24 weeks

5. A woman, having a two year-old child, is registered with you for antenatal care. She is three months pregnant. In the previous pregnancy she has received two doses of T.T. How many doses of T.T. will you advice in the present pregnancy?

Maximum marks - 1

Answer
- One dose

6. At what gestational age, does the foetal heart become audible?

Maximum marks - 1

Answer
- 24-26 weeks

7. What is the expected due date of a pregnant woman with LMP on 26th April 1998?

Maximum marks - 1

Answer
- 2nd Feb, 1999

8. What are the physical effects of violance during pregnancy?

Maximum marks 3

Answer
- Insufficient weight gain
- Vaginal bleeding
- Haemorrhage
- Complications during labour
- Miscarriage
- Ruptured membranes
- Uterine infection
- Death
- Vaginal/Cervical/Kidney infections
- Abdominal trauma
- Exacerbation of chronic illnesses
- Delayed prenatal care
- Low birth weight
- Abruption placenta
- Foetal bruising, fractures and haematomas

9. How do you define childlessness?

Maximum marks - 2

Answer
- Inability to conceive after one year of sexual life without contraceptives.

10. What are the three common causes of childlessness?

Maximum marks - 3

Answer
- Inadequate sperm production
- Failure of ovulation
- Abnormalities in the female genital tract

11. What can the health worker do to help the childless couple? List at least three points.

Maximum marks - 3

Answer
- Provide emotional support
- Explain and give information on causes of infertility
- Protect the couple from falling into the hands of quacks
- Motivate husband to go through essential screening
- Guide and refer the couple to a proper referral centre.
- Ensuring proper compliance during the treatment phase

12. Fill the blanks

Maximum mark

Answer

(a) A sperm count of 20-200 million is normal.

(b) If semen report is abnormal, repeat semen analysis is required to be done three times before investigating the woman.

13 What are the male and female factors resulting in childlessness?

Maximum marks -

Answer

Male Factors	Female Factors
Systemic	Systemic
Psychological	Psychological
Endocrinopathy	Endocrinopathy
Immunologic	Immunologic
Coital Difficulties	
Genital	Genital

14 What are the consequences of childlessness for women?

Maximum marks - 3

Answer

- Marital instability
- Physical violence by husband as a response to childlessness
- Loss of relationship
- Isolation and stigmatisation of childless women
- Woman herself avoids ceremonies
- Women considers herself inauspicious for ceremonies
- Lack of social security and support
- Fear of extinction of family lineage
- Negative feelings: depression and grief, jealousy and anger, guilt and worthlessness, stress
- Loss of important body function

15. The cervical mucus on the 22nd day of menstrual cycle shows a ferning pattern. Does it indicate ovulation / anovulation ?

Maximum marks - 1

Answer

- Anovulation

16. What is the source of vaginal discharge?

Maximum marks - 3

Answer

- Vulva
- Vagina
- Cervix

17. What are the characteristics of normal discharge?

Maximum marks - 3

Answer
- Thin watery discharge
- Normal vulval odour
- Stains underclothes yellow or pale brown

18. What are conditions in which the normal secretions from the vagina increase?

Maximum marks - 4

Answer
- At puberty due to hormonal effects
- During sexual excitement
- At the time of ovulation
- During pregnancy

19. Which are the organisms commonly causing white discharge and the characteristic symptoms due to infection by these organisms ?

Maximum marks - 3

Answer
- Candida albicans -profuse thick curdy white irritant discharge and dysparunia
- Gardenella vaginalis - thin watery greyish discharge and fishy odour.
- Trichomas vaginalis - frothy greenish - yellow with foetid odour.

20. What investigations are required to find the causative organism in a woman complaining of white discharge ?

Maximum marks - 3

Answer
- Wet mount
- Gram stain
- Culture

21. Give the treatment for Candida albicans

Maximum marks - 3

Answer
- Local - Clotrimazole / Miconazole
  Vaginal pessaries - 1 HS/3 days
  or Nystalin vaginal pessaries 1, 00, 000 u for 14 days
- Oral - Tablet Sysconazole 150 mg / 1 day
- or Tab Ketaconazole 2 tabs for 5 days
- Treat male partner

22. What are the gender issues in white discharge and leucorrhoea?

Maximum marks 3

Answer
- Women are usually too shy to talk about white discharge
- Woman found with RTI may be labelled a 'loose woman'
- Decision makers of the family like mother-in-law will take woman to the health centre for problems in pregnancy or infertility than for 'trivial' symptoms like excessive vaginal discharge · Women are taught to silently suffer problems related to their reproductive organs
- Reluctance to seek health services due to inadequate sex education and less access to medical care
- White discharge is generally regarded by women as `normal' and a fact of their existence as women. It is considered stigmatising. When it interferes with their prescribed functions and they have to take treatment.

23. What is the treatment if mucopus is seen on per speculum examination?

Maximum marks - 2

Answer
- Tab Doxycycline 100 mg/ b.d./ 7 days or
- Tab Tetracycline 500 mg/g. ds/7 days
- Tab Erythromicin 500 mg/ g.d.s/7 days
- Treat partners

24. How do you define secondary amenorrhoea ?

Answer
- Cessation of menses for 3 or more cycles following normal menstrual function

25. What are the two types of dysmenorrhoea?

Maximum marks - 2

Answer
- Primary dysmenorrhoea
- Secondary dysmenorrhoea

26. What treatment / advice will you give to woman with dysmenorrhoea who has no detectable abnormality ?

Maximum marks - 3

Answer
- Adequate rest
- Use of hot water bag for fomentation
- Use of laxative
- Personal hygiene
- Drugs like Combiflam 1-1-1 or SOS Diclofenac sodium 1-1-1 Sos

27.(a) List five barriers of communication with patients

(b) Suggest ways to overcome any one of them

Maximum marks - 5

Answer

A) Barriers to communication

1. Personality factors
   - judgemental attitude, biases, prejudice
   - insensitive
   - talking from power position , top-down approach " I know - you don't, I will tell you"
   - lack of warmth and concern
   - inhibition and shyness to communicate in case of STD and reproductive organs
   - distance due to class difference

2. Lack of rapport building skills
   - lack of rapport
   - not listening to them
   - no eye contact

3. Skills in information giving
   - use of medical jargon
   - language
   - not having proper knowledge
   - too much information given at a time
   - non use of appropriate audio visuals
   - not trained

4. External factors

4. External factors
   - time constraint
   - noisy place

5. Gender factor
   - male doctor

B) Suggestions to overcome the barriers

Maximum marks - 7

Answer

1. Personality factors
   - A conscious survey of knowledge, attitude, biases etc. should be undertaken and an
   - attempt should be made to be non judgemental, not exclaiming and understanding

2. Rapport building skills
   - verbal and body language skills should be practised
   - Even if there is a long queue show an interest even in the last patient, trying to
   - establish rapport
   - show her that you are interested in her and respect her

3. Information giving skills
   - proper selection of audio visuals will definitely reinforce suitable messages

4. External factors
   - lean towards her and ask her in a softer voice which others around do not hear in a
   - crowded OPD
   - try to ensure privacy at least with a curtain

5. Gender factor
   - A male doctor sensitive to gender and women's health problems can overcome
   - barriers due to gender factor
   - Also preparing women to interact with the male doctor can make her feel comfortable

28. What are important components of the counselling process?

Maximum marks - 4

Answer

1.Rapport building
   - establishing rapport
   - establishing a trusting and caring relationship with the client

2. Listening and questioning
   - obtaining and giving information

3. Discussion
   - mutual exchange of ideas
   - two way communication process

4. Decision making
   - enable client to make a decision

29. List three ways of establishing rapport with the patient and gaining his / her confidence ?

Maximum marks -3

Answer

- 1. Welcoming her with warmth, introducing, namaskar, greeting etc.
- 2. Asking her to sit down, asking simple questions in the beginning or talkingabout her interests
- 3. Maintaining eye contact
- 4. Warm, friendly, non threatening manner and atmosphere
- 5. Privacy
- 6. Showing respect
- 7. Ensuring confidentiality
- 8. Showing interest and care
- 9. Avoiding being judgemental
- 10. Not dominating

30. How can the following questions be asked differently to get more information from the patient ?

Maximum marks -5

Answer

(a) Is the colour of discharge yellow? Is it grey?

- What is the colour of the discharge?

(b) Do you have problems while having intercourse?

- What problems do you have while having intercourse?
- How do you feel during intercourse?

(c) Do you have any other problems?

- What other problems do you have?

(d) Don't you think having three children is enough?

- What do you think about having three children?
- How many children do you think one should have?

(e) Did you use the pills for regular menses?

- What did you use the pill for?

31. What local terms are used for the following words?

Maximum marks - 9

Answer

(a) Intercourse : Sambandh
(b) Vaginal discharge : angawarun pani jane, strav
(c) Semen : dhatu, aadmi ka pani
(d) Genital / Genital area : laghvichi Jaaga, pishab ki jagah,
(e) Menstrual period : pali , mahina,masik
(f) Uterus : thaili, pishvi, garbhashay, garbhachi pishvi, bachedani
(g) Vagina : yoni, Aatlye ang, mayang, samb and hachi jaga, mc chi jaga
(h) Ovaries : andkosh, andyachi pishvi
(i) fallopian tubes : nali, bachedani ki nali

32. List three factors to be considered while sending the patient to a referral centre.

Maximum marks -3

Answer

- Time
- Cost
- Distance
- Whether referral slip is filled completely or not
- Confirming whether the patient has understood the importance and instructions for referral

33. How can you help the woman understand the information that you are giving her? (Any three)

Maximum marks - 5

Answer

1. Finding out what information she needs
   - Start from her level, first find out what and how much she already knows about the topic
   - give relevant and necessary information
   - avoid giving complex and unnecessary details which might only confuse her

2. Planning and organising the information - phase out the information
   - give accurate information
   - give the information in an organised and logical manner
3. Making the sessions interactive -encourage the woman to ask questions
   - observe non verbal communication and respond to her needs and doubts

4 . Language and delivery
   - use simple language, avoid using jargon
   - use of local terminology

5. Use of A/V material

34. How can you reduce shyness and fear of a woman who is going for internal examination? (Any three)

Maximum marks - 3

Answer

1. Rapport building
   - say: I know how you feel- every woman is bound to feel shy and apprehensive (if you are a lady doctor you could say that is exactly what you felt when you had your first internal) but please remember I have done many such examinations before, and I will try not to hurt you.
   - do a general examination first so that she gets to know you and builds her confidence in you
   - Be reassuring

2. Preparation
   - preparing and telling her in case of a male doctor
   - preparing her mentally and taking her consent
   - giving her time to prepare physically
   - providing privacy for removing or loosening her under clothes

3. Explanation
   - explaining the examination procedure (what and why)

4.Privacy during examination
   - covering her with a sheet during examination
   - see that no body else enters while the examination is being done

5. Respect
   - tell her to take the position in respectful and caring way

6. Make her feel comfortable during examination
   - keep talking to her and keep the easy conversation on (ask her name , talk to her first
   - about her family, her problem)
   - make her feel that you are focussing on her as a whole and not only on her
   - reproductive tract

35. All diseases affect men and women similarly ? Agree /disagree

Maximum marks -1

Answer
- Disagree

36.Women's health problems are the concern of women only. Men should not be bothered with these. Agree/disagree

Maximum marks -1

Answer
- Disagree

Name of the participant:

Name of the facility where working:

Date:

Annexure 2.5

EVALUATION OF WORKSHOP SESSIONS

	INFORMATION	DURATION	TRAINING METHOD	SUGGESTIONS FOR IMPROVEMENT
	ADEQUATE INADEQUATE NOT RELEVANT	ADEQUATE INADEQUATE	APPROPRIATE INAPPROPRIATE LENGTHY	
1. Women's Health Problems (Group Exercise & Discussion)				
2. Gender & Health				
3. Brainstorming (Integration of Health Post /Dispensary)				
4. Communication Skills				
5. Counselling Skills				
6. Menstrual Problems (Lecture)				
7. Menstrual Problems (Group Exercise)				
8. Leucorrhoea (Lecture)				
9. Sexually Transmitted Infections (Lecture)				
10. Reproductive Tract Infections (Group Exercise & Discussion)				
11. Antenatal Care (Lecture)				
12. Antenatal Care (Group Exercise & Discussion)				
13. Childlessness (Lecture)				
14. Childlessness (Group Exercise & Discussion)				

a) Which session did you like the best and why?

b) Which session you did not like and why?

c) Do you think similar refresher training courses should be held for clinicians regularly?

Name of participant:

Name of facility where the participant is working:

Date:

Annexure 2.6

EVALUATION OF FIELD TRAINING

	GYNAEC OPD	ANTENATAL OPD
Name of the hospital where training was received		
Number of days for which you attended the OPD		
Training received useful (Yes or No)		
Duration of Training (adequate/inadequate/ more than adequate)		
Any problems faced by you during the field training		
Suggestions for improving the field training		

Name of participant:

Name of facility where the participant is working:

Date:

TOOLS FOR MONITORING

MONTHLY REPORT FROM GYNAECOLOGY CLINICS

Name of Facility: ..... Ward: ..... Month: .....

TYPE	OLD PATIENTS			NEW PATIENTS				NUMBER OF CASES COUNSELLED AS PER CHECKLIST*		TOTAL	
								Women	Men	Women	Men
Menstrual Problems											
Childlessness											
ANC											
	Women	Men	Partner Treatment		Women	Men	Partner Treatment			Women	Men	PartnerTreatment
			Medicines	Condom			Medicines	Condom				Medicines Condom
Reproductive Tract Infections Sexually Transmitted Infections												

* Please refer to 'Observation Checklist for Leucorrhoea'

ADMINISTRATIVE SUPERVISORY CHECKLIST FOR GYNAECOLOGY CLINIC

	Available Quantity	Remarks (Note reasons for non availability)
Drug supply		
Gloves		

Instruments and equipment	Working condition		Remarks (Note reasons for non working)
	Working	Non working	

	Adequate	Not adequate	Remarks (Note reasons for non adequacy)
Water supply			
Sterilisation procedure followed			
Privacy			

Staff availability	Normal	Staff present on a day of visit	

Training needs identified

Action Plan to be summarised from remarks

Copy to M.O.H.

TECHNICAL SUPERVISORY CHECKLIST

Name of the Facility :..... Date : .....

Sr.No.		No. of cases reviewed	Satisfactory	Non satisfactory	Inadequate	Remarks
1	History taking					
2	Examination					Reasons for PV not done
3	Investigation					
4	Management					Drugs - Reasons for non availability Partner treatment
5	Referral					Reasons for referral Facility referred to
6	Follow up					

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